Portland Police Bureau

Crisis Intervention Team

Instruction Manual

CIT Mission Statement:

"The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis."

Section 1 – MENTAL ILLNESS

***Overview of Mental Illness**

***Childhood Disorders**

***Personality Disorders**

***Post Traumatic Stress Disorder**

***Alcohol and Drugs**

Overview of Mental Illness

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FACTS ABOUT MENTAL ILLNESS

- Mental illnesses are physical brain disorders that profoundly disrupt a person's ability to think, feel, and relate to others and their environment.
- Mental illnesses are more common than cancer, diabetes, or heart disease.
- In any given year, more than five million Americans suffer from an acute episode of mental illness.
- One in every five families is affected in their lifetime by a severe mental illness, such as bipolar disorder, schizophrenia and major depression.
- One in ten children and adolescents have mental illnesses severe enough to cause some level of impairment. Yet fewer than one in five of these young people receives needed treatment.
- The treatment success rate for schizophrenia is 60 percent, 65 percent for major depression, and 80 percent for bipolar disorder. Comparatively, the success rate for treatments of heart disease ranges from 41- 52 percent.
- The number one reason for hospital admissions nationwide is a biological psychiatric condition. At any moment, almost 21 percent of all hospital beds are filled by people with a mental illness.
- The total price tag of mental illnesses in this country is $148 billion, including direct costs (hospitalizations, medications) and indirect costs (lost wages, family caregiving, losses due to suicide).
- Despite media focus on the exceptions, individuals receiving treatment for schizophrenia are no more prone to violence than the general public. Unfortunately, almost one-third of all U.S. jails incarcerate people with severe mental illnesses who have no charges against them, but are merely waiting for psychiatric evaluation or the availability of a psychiatric hospital bed. Today, roughly 283,000 people with severe mental illnesses are incarcerated in jails and prisons, mostly for crimes they committed because they were not being treated for their illness.
- On any given day, approximately 150,000 people with severe mental illness are homeless, living on the streets or in public shelters.
- Roughly 80 to 90 percent of people with serious brain disorders are unemployed.

CRISIS INTERVENTION TEAM TRAINING
MAY 15, 2000

OVERVIEW OF MENTAL ILLNESS

WHAT IS MENTAL ILLNESS?

A biologically based brain disease characterized by

- perceptual disturbance
- mood lability
- lack of motivation
- and in extreme cases, suicidality.

Mental Illness can impact all areas of a person's functioning including

- **Social** — difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
- **Occupational** — difficulty acquiring and/or maintaining employment
- **Interpersonal** — difficulty maintaining relationships with friends, co-workers, partners, spouses, parents, children

Symptoms of mental illness may be exacerbated by environmental stressors including

- Poverty
- Homelessness
- Difficulty accessing medical care
- Poor nutrition
- Drug and alcohol addiction

Symptoms of mental illness may be alleviated by medicine and social supports including

Help in --

- keeping up an apartment
- shopping for food
- budgeting money
- attending to hygiene
- planning social activities
- making friends and maintaining relationships
- Easy access to mental health care that is affordable and tailored to the needs of the person

WHAT MENTAL ILLNESS IS NOT

- Mental illness is not a character flaw.
- Mental illness is not a guarantee that the person will be violent.
- Mental illness is not anyone's fault.
- Having a mental illness does not mean there is no hope.

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Thought Disorders

- Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
- Talk to self
- disorganized thoughts
- Paranoia, delusions, or bizarre thoughts
- Minimal display of emotion
- Poor hygiene/malodorous
- May wear multiple layers of clothing or inappropriate clothes for the weather
- May have multiple bags filled with what might appear to be garbage

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Mania:

- Expansive irritable mood
- Decreased need for sleep
- Heightened self-esteem
- Grandiose ideas
- Pressured speech /inability to interrupt them
- Distractibility
- Poor impulse control (e.g. buying sprees, sexual indiscretions)
- Possible break with reality, i.e. psychosis

WHAT A PERSON WITH MENTAL ILLENSS MIGHT EXPERIENCE

People with major depressive disorder often do not act in a bizarre manner

Common symptoms of depression include:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in all or most activities of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Feelings of worthlessness
- Recurrent thoughts of death or thoughts of suicide

It is a myth that depression is a normal part of the aging process. It is important to remember that depression is an illness which can be successfully treated.

IF YOU HAVE TO TAKE THE PERSON INTO CUSTODY ON A HOLD SOMETIMES IT IS HELPFUL TO:

- Ask the person if they have ever been in handcuffs before
- Tell the person that you came to help them, not to hurt them
- Tell them they are not under arrest or in trouble
- Tell them you know that they are not a bad person
- Tell them your boss says you have to put them in handcuffs, it is the rule, it's nothing personal

NOTES

Basic **P**sychiatric **L**ife **S**upport

Portland Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

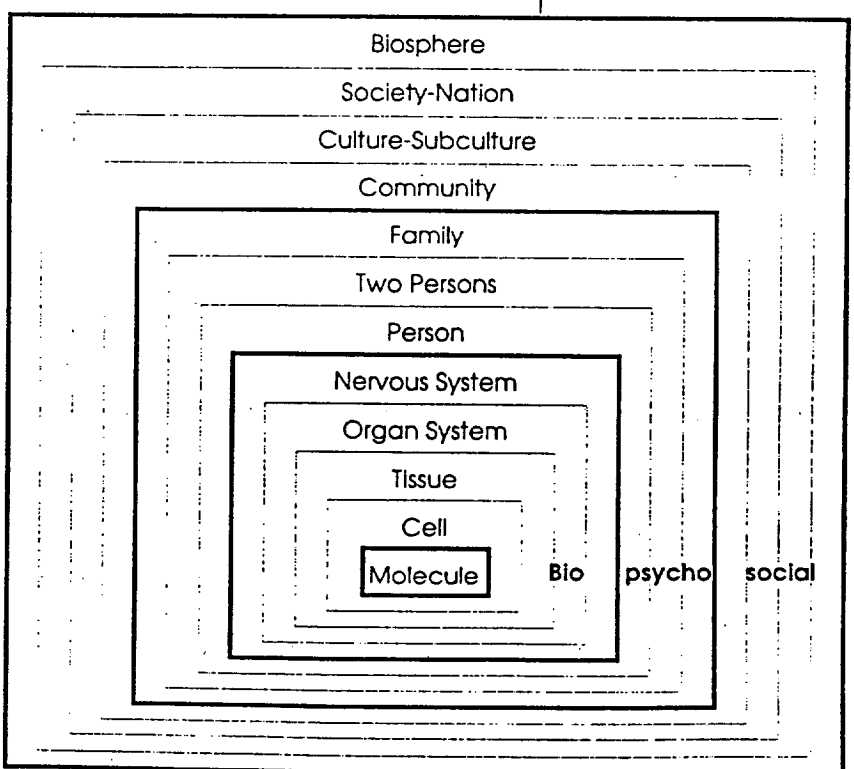


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

Top priority must be the professional's immediate physical safety.

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?
Urgency: How fast must a response occur to be effective?
Remediability: How much difference will any response make?
Sequence: Does one step require a prior step?
Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

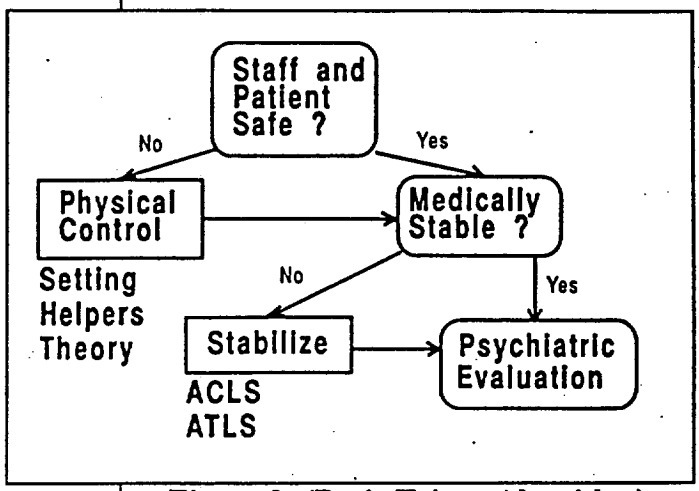


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:

To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:

Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

4.1.2 Personnel:

Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

Estimating the patient's control and deciding when the professional must assume control is key.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("if...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid) (Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

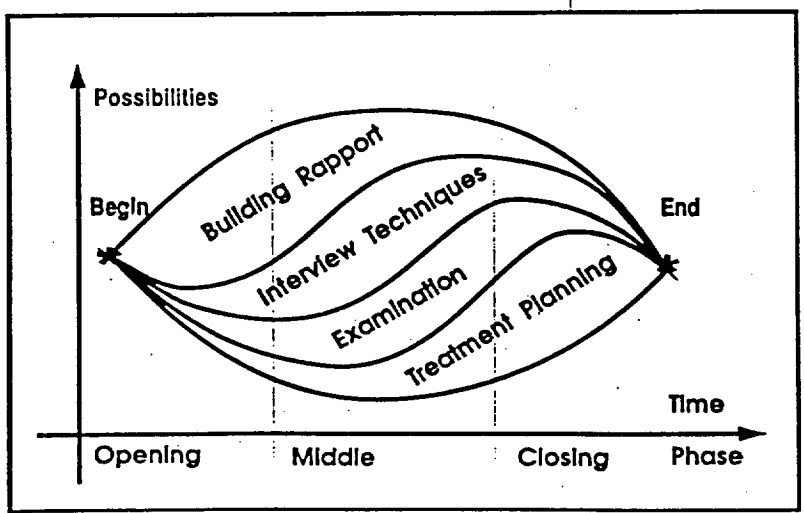


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

Knowing the relative importance of historical information can lead the interview.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:

The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:

The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

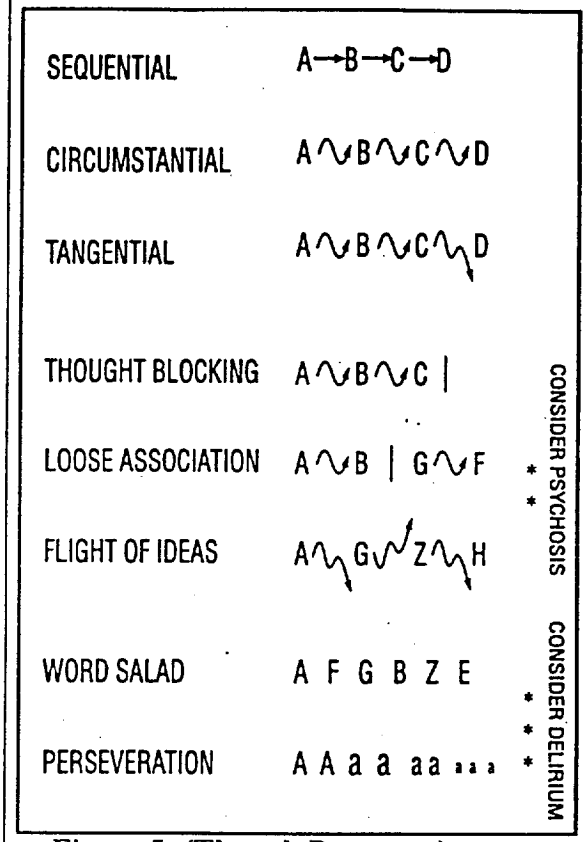


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a non-bizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes: Stamped envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

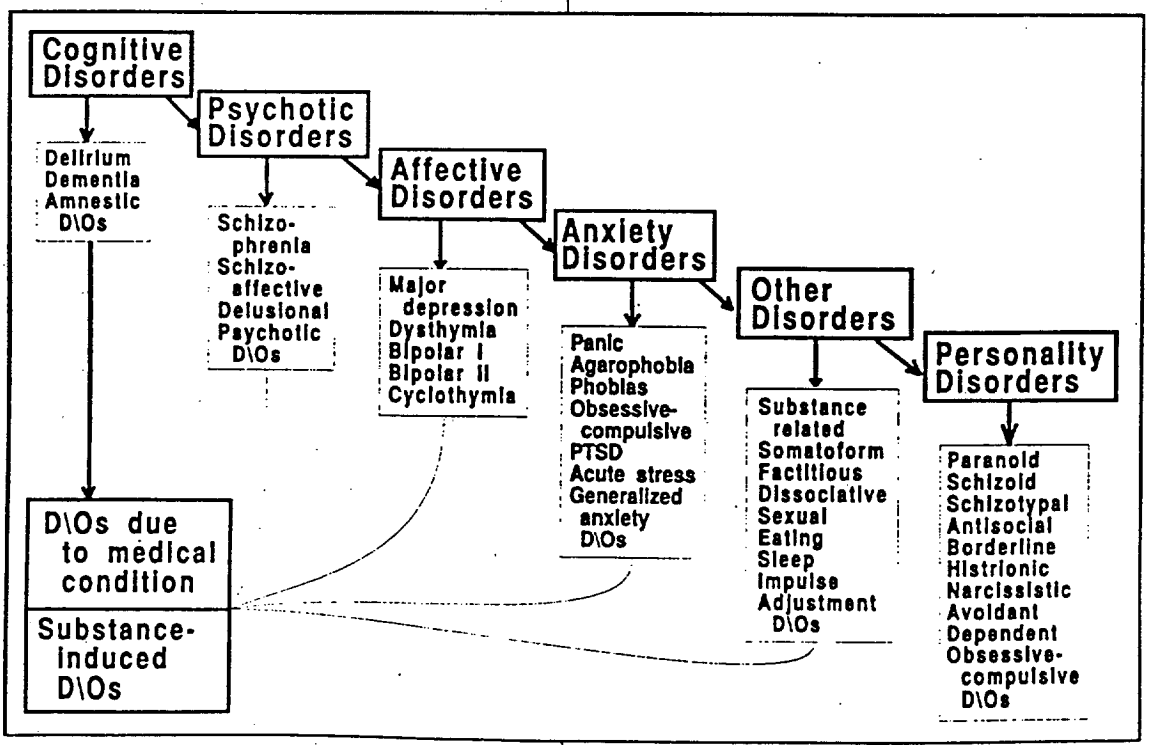
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

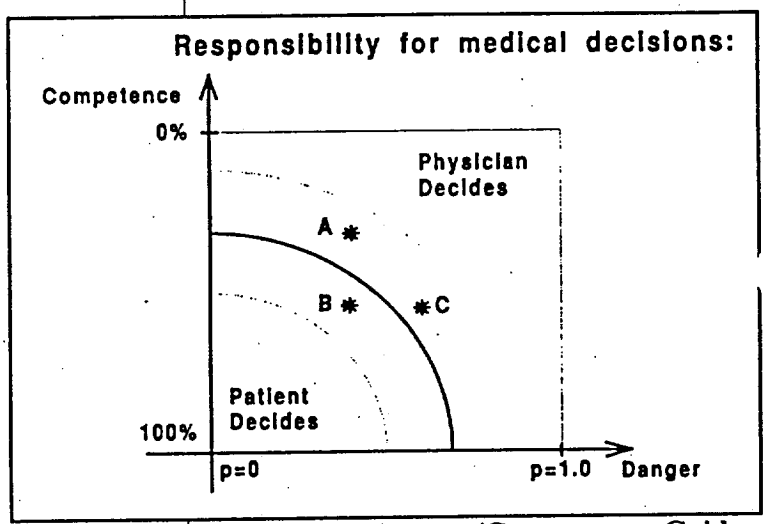


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

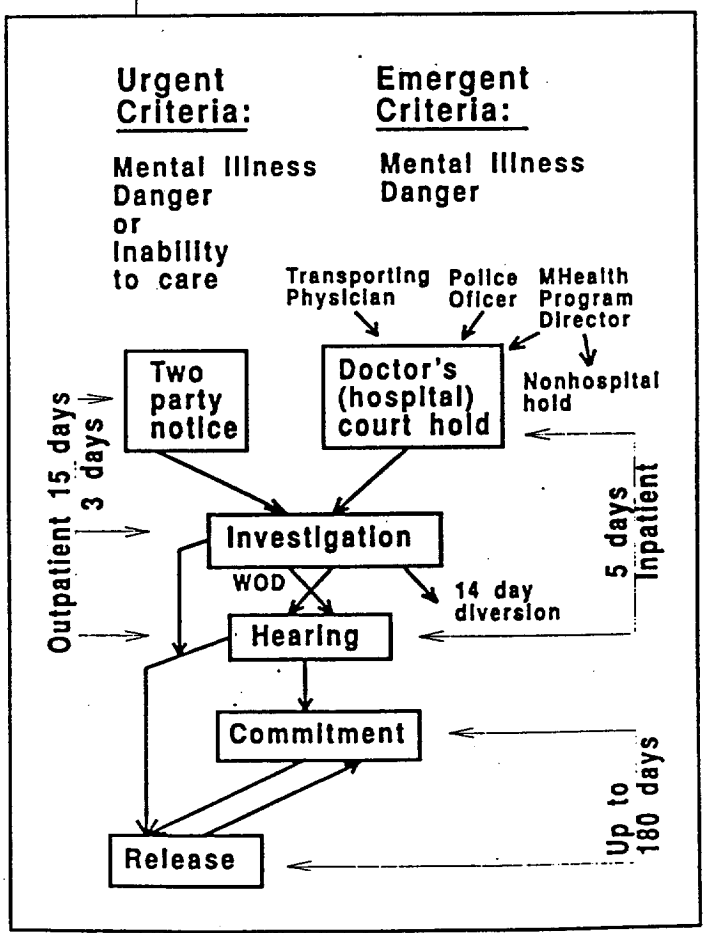


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

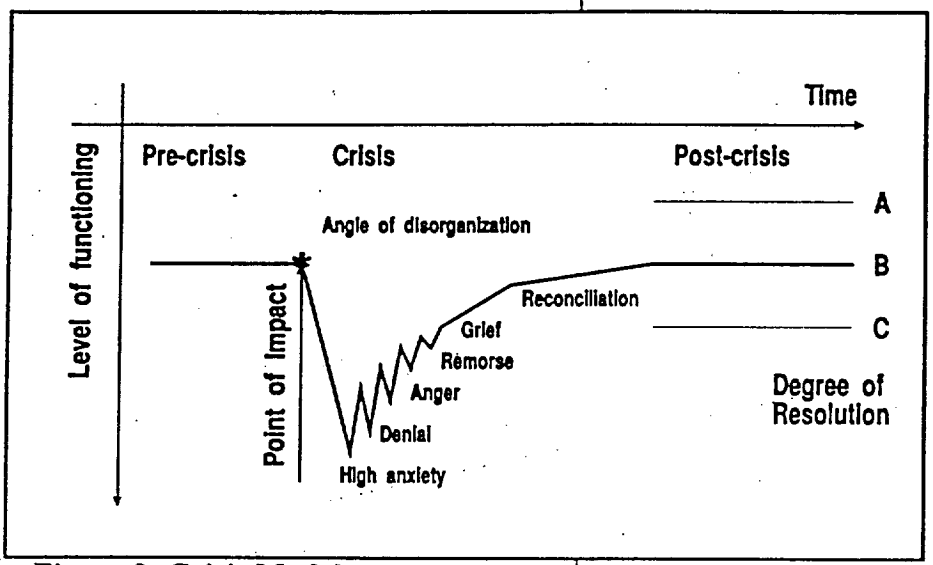


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

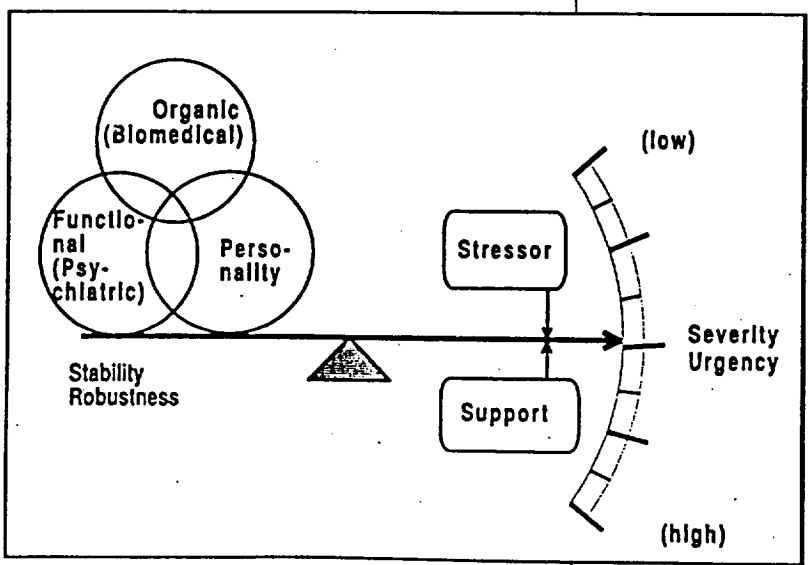


Figure 10: Crisis Intervention

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires, yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

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NOTES

NOTES

ORGANIC AND PSYCHOTIC

MENTAL ILLNESS

WHAT IS PSYCHOSIS

Psychosis is defined by a complex of symptoms which include:

Delusions (false beliefs in something that is so at odds with the prevailing societal consensus as to be recognized as ranging from the improbable to the bizarre).

Hallucinations (the experience of sensation in the absence of external stimulation, most commonly auditory, but in drug induced states or other organic states can include visual, olfactory, gustatory, and tactile sensations).

Incoherence (unintelligible speech or speech which may make sense but conveys little or no information even though the person may talk a lot).

Loosening of Associations (the lack of connection in a person's flow of thought so that ideas seem to generate other ideas which have no logic to their sequence).

Catatonia (marked excitement or profound stupor and muteness to the degree that a person is at risk for life threatening exhaustion or is unable to carry out basic functions such as food seeking and feeding).

Gross Disorganization (marked difficulty in organizing behavior so that a person may be disoriented to time, place and identity, may be unable to respond to others or unable to respond in an understandable manner).

There are a range of conditions which may produce psychotic behavior ranging from; a brief reactive psychosis which is a response to excessively traumatic stress (for example: combat); to substance induced psychotic reactions; to psychosis due to a progressive brain deterioration such as in a dementia like Alzheimer's; and psychosis due to a chronic mental disorder such as schizophrenia or severe mood disorder as in psychotic depression or in psychotic mania.

The neurobiological basis of psychosis appears to stem largely, but not exclusively, from the disruption of dopamine transporting systems in the brain. This can be due to endogenous (internal) causes such as mental illness or dementia but also may be due to exogenous (external) causes such as head trauma or exposure to certain chemicals.

For our purposes, **we are concerned with those chemicals which have reinforcing properties in the brain and are likely to be abused.** Repeated use of substances such as **alcohol, speed, crank, coke, crack, hallucinogenics, designer**

drugs, increases the risk of developing a drug induced psychosis or "triggering" an existing condition such as schizophrenia or severe mood disorder. This appears to be due to the dopaminergic (dopamine stimulating) action of these substances in the brain.

The most common psychiatric symptom resulting from repeated or heavy use of any of the amphetamine type drugs is delusional thinking. Paranoid delusions of persecution and other bizarre or unusual explanations of events are frequently seen. Accompanying this paranoia can be agitation, anxiety and aggressive behavior so that persons in a drug induced psychotic state have much more potential for violent acts including homicide and suicide.

Think of the brain as an elaborate circuit board with very complex electrical interconnections which form our self-awareness, our experiences, our thoughts, our sensations, our perceptions, our memories. If you pour water on a circuit board it shorts out due to the water acting as an electrical conductor between parts of the circuits that weren't meant to be connected. Drugs act the same way in the brain except instead of water being the disruptive electrical conductor, they act on the neurotransmitters which conduct electrical activity. If the brain is no longer able to carry out established interconnected patterns of electrical activity and different pathways become involved, what the brain experiences is psychosis. What others see is that the psychotic person does not make sense and that is responding to stimulation which is internal and not shared or understood by others.

Usually, if an individual abstains from drugs, **the psychotic symptoms will go away with time.** The symptoms generally go away within hours to days, although they may last several months and, for some unfortunate individuals, they may become permanent. **The population at highest risk for permanent damage is the one with an existing mental illness or mood disorder or, has a predisposition to develop a mental illness or mood disorder.**

At this time, the only known effective treatment for psychotic disorders is the use of anti-psychotic medications which tend to have a stabilizing effect on the dopamine balance in the brain. These medications are not 100% effective and they carry some risk of side effects. About 25% of people with psychotic symptoms do not obtain a favorable response to existing anti-psychotic medications. Hallucinations, confusion and disorganization generally respond to anti-psychotic medications but delusional thinking tends to be less responsive.

Denial is a major element making for great difficulty in the treatment of psychotic states that are either drug induced or due to chronic mental disorders. Frequently, the person experiencing the psychotic effects of drugs or of mental illness believes that what his senses are telling him is an accurate reflection of

external reality. This is what we all believe and rely on to navigate through the world. When someone tells a psychotic individual that what they are experiencing is not "real", it is very difficult to make a convincing argument. What is going on in that person's brain is their reality so they must deny any challenges to that reality and refuse to accept any offers of treatment and refuse to believe that they might need treatment.

A common outcome is that a psychotic person comes to the attention of the police. A quick determination is made if the psychotic person poses some danger to themselves or others and is not willing to obtain voluntary treatment. **The individual is transported to an emergency psychiatric facility where they can be detained against their will, for up to five court days.** During this time an investigator must make a determination as to whether or not the person is to go to Civil Court before a judge and psychiatric examiners for an involuntary commitment hearing. **The Civil Court has the authority to place the person under the care and custody of the Mental Health Division for a period not to exceed 180 days if they find the person continues to be mentally ill and a danger to self or others. While under commitment a person can be administered psychiatric medications against their will.**

Go back now to the earlier statement that most drug induced psychotic states clear in a few hours to a few days. If a person in this condition is taken to a psychiatric emergency holding facility they are likely to be released without a commitment hearing. **But, for the person whose symptoms persist, they stand a good chance of being committed and placed in a psychiatric hospital.**

If a crime was committed at the time the person was picked up by the police, the person will probably have a **detainer** placed on them while in the hospital and then be transferred to jail once their symptoms have cleared. **Petty crimes** committed while the person is psychotic are often dismissed if the court feels that the individual is getting the treatment they need. Repeat offenders are not as likely to be looked upon with such leniency particularly if they persist in denying they need treatment or do not follow through with treatment.

Mental illness is not a state of bliss. It can be a world filled with fear and confusion. Whether psychosis is drug induced or not doesn't make any difference to your brain but **the choice to use or not use drugs of abuse will make a major difference in how your brain is going to function.**

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche"=the mind and "tropos"=turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics, that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly rapid tolerance and are extremely difficulty to withdraw from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal is actually easier, quicker and safer. Common side effects are sedation, dry mouth, depression, memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do not produce tolerance. The anti-depressants work to restore balance in the neurotransmitter systems which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics

Elavil (amitriptyline)
Tofranil (imipramine)
Norpramine (desipramine)

Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

the **second generation or "atypical" compounds**
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)

the **SSRI's** (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

the **MAOs** (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The **ANTI-MANICS** are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. **Non-addictive** and does not produce tolerance. Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they work to restore balance in the neurotransmitter systems which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance. Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)

Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
the **"new generation"** anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Orap (pimozide) used mainly for Tourette's Syndrome
GOOD ONE
The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. These medications can produce dependence and tolerance. They are less often prescribed now as many of the SSRI anti-depressants and a couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)

There are others in all the above classes but this list is fairly inclusive.

Organic Disorders

a. Definition
    1. A class of conditions caused directly by abnormalities of brain structure or by alterations of brain neurochemistry or neurophysiology (e.g., delirium, dementia, amnesic syndrome, organic hallucinosis, organic delusional syndrome, organic mood syndrome, organic personality syndrome, etc.)

b. General symptoms
    1. Confusion, memory disturbance, disjointed speech, slow mentation, and substance abuse

    2. Physical signs
        a. Breath smells
        b. Blood shot eyes
        c. Runny nose
        d. Needle tracks
        e. Slurred speech
        f. Unsteady on feet
        g. Bizarre behavior and speech

    3. Head Trauma
        a. Permanent
        b. Slow mentation
        c. Impulsive
        d. Seizures
        e. Personality change

    4. Stroke
        a. Usually older person
        b. Paralysis
        c. Difficulty speaking

5. Dementia
   a. Older person
   b. Confused, especially about personal information
   c. Combative
   d. Often in a nursing home or has a specific care provider

6. Medical Causes
   a. Diabetic not taking insulin
   b. Drug overdose
   c. Delirium – fluctuating levels of consciousness
   d. Past seizures
   e. Off seizure medications
   f. Physical illness (sweating, nausea, vomiting)

Psychotic Disorders

a. Definition
   1. A disturbance of perception and thought process is a broad description of this category. The psychotic symptoms represent manifestations of disturbances in the flow, processing, and interpretation of information in the central nervous system. These symptoms can be mild to severe. (Mental Health : A Report of the Surgeon General)
   2. Hallucinations are the most common group of symptoms that result from this disordered processing and interpretation of sensory information. An example is the frequently described hallucination of hearing voices.
   3. Hallucinations may include:
      a. auditory
      b. smell
      c. feel
      d. visual
      e. physical
   4. Delusions are a more complex group of symptoms resulting from this disordered interpretation of information. A delusion is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others are trying to harm him. Any attempts to persuade the person that these beliefs are unfounded typically fail and may further entrench the delusional belief.
   5. Psychotic thought processes are characteristically loose, disorganized, illogical, or bizarre. These thought processes frequently produce bizarre observable patters of behavior that is also disorganized and bizarre.

Schizophrenia

a. The cause of schizophrenia has not yet been determined although research points to the interaction of genetic endowment and major environmental upheaval during the development of the brain. (Mental Health: A Report of the Surgeon General)
b. Part of the psychotic disorders schizophrenia frequently have marked disturbances in logical thought process.
c. Symptoms can include:
    1. Hallucinations
    2. Delusions
    3. Disorganized thoughts and behaviors
    4. Loose or illogical thoughts
    5. Agitation
    6. Flat or blunted affect
    7. Concrete thoughts
    8. Anhedonia (inability to experience pleasure
    9. Poor motivation, spontaneity, and initiative

MOOD DISORDERS

Mood Disorders

a. A group of clinical conditions characterized by a disturbance of mood, loss of that sense of control, and a subjective experience of great distress. This disturbance of mood can be manifested by either stained feeling or sustained elevation of mood. As with psychosis the disturbance of the mood occurs in a variety of patterns associated with different mental illnesses. (Mental Health: A Report of the Surgeon General)

Bipolar or Manic Depressive

a. Symptoms include mood swings from the lows of depression to the highs of mania. These episodes alternate and in some cases can be predicted. Severely affected people have a "rapid cycling" bipolar illness, in which the mood swings occur almost continuously.
b. Depression: symptoms include melancholy, sad, miserable most of the time. Loss of interest in life and pleasures. There can be a decreased energy level, fatigue, fits of weeping or constantly feeling like crying, and an unusually high degree of irritability. There is also a on going thoughts of suicide in severe cases.
c. Manic symptoms include a feeling of power, increased energy, seductive, elated, euphoric. Other symptoms include talks too fast, loud and without stopping. Thoughts race from one idea to the next in rapid succession without much logic. Stop eating, sleeping which in turn can change mood to irritability, anger, paranoia.

Major Depression

a. Ongoing feelings of melancholy, sad and miserable most of the time with loss of interest in life and pleasures. These episodes can also include decreased energy, fatigue, fits of weeping or constantly feeling like crying. Symptoms may

vary with individual, but are long lasting and affect the quality of life for the person.

b. The though process is constantly negative with hopelessness dominating present and future. Anxiety, dread can increased the individual's inability to function. Difficulty in concentration and making decisions; experience feelings of guilt, self-loathing, or worthlessness. Preoccupies with death and suicidal thoughts or attempts.
c. Physically individuals may experience disruptions in normal eating and sleeping patterns. Some are unable to sleep and others may sleep more hours than usual.
d. Behavior includes inability to get work done and difficulty in reading or studying. There is a great difficulty in accomplishing simply tasks such as washing, dressing, and eating. There may also be some restlessness and agitation. The characteristics include slowed thoughts, movements, and speech; walk stooped and shuffling gait

NOTES

Childhood Disorders

Psychiatric Disorders in Children and Adolescents

- About 20% of US children and adolescents (15 million), ages 9-17, have a diagnosable psychiatric disorders.
- As reported in the Surgeon General's Conference on Children's Mental Health in January, 2001:
  1 One in ten children and adolescents suffer some mental illness severe enough to cause some level of impairment.
  2 It is estimated that fewer than one in five of these children receive needed treatment in any given year.

I. Social background

A. Barriers to treatment

1. Limited governmental funding directed toward child and adolescent mental health services.
2. Limited treatment services/programs.
   - Less mental health treatment services for children than for adults.
     In Portland, the number of psychiatric inpatient beds for:
     Adults=193
     Children and adolescents=52
3. Increasing number of child and adolescent patients.
   - At CTC, number of patients seen under 18:
     In 1997 = 360
     In 2000 = 1,492
4. Increasing demand for mental health professionals.
   - Children and adolescent patients may wait 6–8 weeks or longer for an appointment with a child and adolescent psychiatrist

B. Stigma

Parents may be fearful they may be blamed for their child's emotional and behavioral problems. Children are sometimes teased or directly stigmatized by classmates.

II. Common Disorders

Four disorders (ADHD, Oppositional-Defect Disorder, Conduct Disorder and Autism) have onset and are usually first diagnosed in childhood or Adolescence.

A. Disruptive Behavior Disorders

1. Attention-Deficit/Hyperactivity Disorder

- A disorder where an inappropriate degree of hyperactivity-impulsivity and/or inattention is exhibited.
- Some of the following symptoms must be present before age 7.
- More frequent in males than females.

- Prevalence – 3-5% in school aged children.
- Most commonly diagnosed disorder in child/adolescent psychiatry.
- Symptoms

  a. Inattention

  1. Often fails to give close attention to details, makes careless mistakes in schoolwork, or other activities.
  2. Often has difficulty sustaining attention in tasks or play activities.
  3. Often doesn't seem to listen when spoken to directly.
  4. Often doesn't follow through on instructions and fails to finish schoolwork or chores.
  5. Often has difficulty organizing tasks and activities.
  6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork, homework).
  7. Often loses things necessary for tasks and activities (e.g., toys, school assignments, pencils, books).
  8. Is often easily distracted by extraneous stimuli.
  9. Is often forgetful in daily activities.

  b. Hyperactivity:

  1. Fidgets with hands, squirms in seat.
  2. Often leaves seat (in classroom).
  3. Often runs about, climbs excessively in situations in which it is inappropriate (In adolescents may be limited to feelings of restlessness).
  4. Often has difficulty playing or engaging in leisure activities quietly.
  5. Is often "on the go" or acts as if "driven by a motor".
  6. Often talks excessively.

  c. Impulsivity:

  7. Often blurts out answers before questions have been completed.
  8. Often has difficulty awaiting turn.
  9. Often interrupts or intrudes upon others (e.g., butts into conversations or games).

- Associated disorders or symptoms

  Learning disorders.
  Oppositional Defiant Disorder-tantrums, bossiness, stubbornness, poor patience.
  Conduct Disorder-aggression.
  Mood disorders-poor self esteem, depression, rejection by peers, and conflict with family.

2. **Oppositional-Defiant Disorder**

- A disorder where children or adolescents display a pattern of openly uncooperative and negative, disobedient and hostile behavior.
- More prevalent in males than females before puberty; rates equal after puberty.
- Usually evident before age 8.
- Symptoms
  1. Often loses temper.
  2. Often argues with adults.
  3. Often actively defies or refuse to comply with adult's request or rules.
  4. Often deliberately annoys people.
  5. Often blames others for his/her mistakes or misbehavior.
  6. Is often touchy or easily annoyed by others.
  7. Is often angry or resentful.
  8. Is often spiteful or vindictive.
- Associated disorders or symptoms

  ADHD is common.

  Oppositional-defiant disorder can (but does not always) precede conduct disorder.

  Depression – low self-esteem.

  Substance abuse.

3. **Conduct Disorder**

- A disorder in which there is a repetitive and persistent pattern of the violation of the basic rights of others OR major age appropriate roles.
- More common in males than females.
- May begin in childhood or adolescence.
- Symptoms

  a. Aggression to people and animals
     1. Often bullies, threatens, intimidates others.
     2. Often initiates physical fights.
     3. Has used a weapon (e.g. bat, brick, broken bottle, knife, gun) that can cause serious physical harm.
     4. Has been physically cruel to people.
     5. Has been physical cruel to animals.
     6. Has stolen while confronting a victim (mugging, purse-snatching, extortion, bank robbery).
     7. Has forced someone into sexual activity.

b. Destruction of property
   8. Has deliberately engaged in fire setting with intention of causing serious damage.
   9. Has deliberately destroyed others' property.

c. Deceitfulness or theft
   10. Has broken into someone else's house, building, car.
   11. Often lies to obtain goods/favors or avoid obligations.
   12. Has stolen items of nontrivial value without confrontation of a victim (e.g. shoplifting, forgery).

d. Serious violation of rules
   13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
   14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
   15. Often truant from school, beginning before age 13 years.

- Associated disorders or symptoms
  ADHD.
  ODD (may precede CD) –temper outbursts, poor frustration tolerance.
  Depression – low self-esteem, irritability.
  Substance abuse.

- **Police response to children and adolescents with a disruptive behavior disorder (ADHD, ODD, CD)**
  a. Usually police come into contact with these children or adolescents because of their anger outbursts or physical and/or verbal threats of harm.
  b. They may be argumentative or minimize problem behaviors.
  c. Direct questioning with authoritative approach.
  d. Obtain and carefully consider information provided by adult witnesses.
  e. Inquire whether the child is in current mental health treatment and (if applicable) taking medications.

B. Autistic Disorder (to be covered in Developmental Disability section)

- A disorder characterized by patterns of delay and impairment in the development of social interaction and communication and the development of restricted interests and activities.
- Onset is prior to age 3 years.
- 3 to 4 times more common in males.
- Coexistent disorders or symptoms
  Mental retardation 20% have normal IQ.
  30% have mild to moderate mental retardation.
  50% have severe or profound mental retardation.

ADHD – disruptive, impulsive.
Self-injury (e.g., head banging).
Obsessive – compulsive disorder – compulsive, repetitive behaviors.

- **Police response to children and adolescents with Autistic Disorders.**
  a. Usually police come into contact with these children because of self-injury, impulsive behaviors or anger outbursts.
  b. These children are unlikely to make eye contact or communicate/answer any questions.
  c. Obtain as much information from adult witnesses, parents or guardian.
  d. These children do not do well with change. If they have an attachment to an object, consider letting them hold on to it.

C. Anxiety Disorders

- The most common mental health problem that occurs in children and adolescents.
- According to one large-scale study of 9-17 year olds, as many as 13% had an anxiety disorder in a year.
- Common anxiety disorders

1. Phobias

- Excessive or unreasonable marked and persistent fear of a specific object or situation or fear of a social or performance situation where the person is exposed to scrutiny and fears embarrassment.
- Exposure to that object or situation causes an immediate anxiety response. In children, anxiety may be expressed by crying, tantruming, freezing or clinging.
- In children, most common fears-fear of dark, fear of harm to an attachment figure; fear of animals.
- In adolescents – fear of heights, fear of public speaking.

2. Generalized Anxiety Disorder

- A disorder characterized by excessive anxiety and worry, where the individual finds it difficult to control the worry.
- Most common in middle childhood.
- Symptoms (only one required for children): Restlessness or feeling keyed up or on edge, being easily fatigued; difficulty concentrating or mind going blank, irritability, muscle tension, or sleep disturbance.

3. Panic Disorder

- A disorder characterized by recurrent, unexpected panic attacks.
- Panic attacks are discrete periods of intense fear or discomfort in which symptoms develop abruptly and reach a peak within 10 minutes.

- Symptoms include palpitations, sweating, trembling, shortness or breath, feeling of choking, chest pain, nausea, dizziness, derealization or depersonalization, fear of losing control or fear of dying.
- Uncommon before puberty.
- Usually begins in adolescence or early adulthood.

4. **Obsessive-Compulsive Disorder**
   - A disorder characterized by recurrent obsessions or compulsions that cause distress, are time consuming, or interfere with individual's functioning.
   - Majority of children and adolescents have both obsessions and compulsions.
   - Mean age of onset = 10 years.
   - Obsessions: Recurrent or persistent thoughts, impulses or images that are experienced as intensive and inappropriate, cause marked anxiety or distress and are not simply excessive worries about real-life problems.
   - Compulsions: Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession. The behaviors or mental acts are aimed at preventing or reducing distress.
   - Most common symptoms of OCD in childhood are obsessive contamination fears accompanied by compulsive washing and avoidance of contaminated objects.
5. **Post-traumatic Stress Disorders**. (will be covered in PTSD section)
   - Disorder where child/adolescent has been exposed to a traumatic event, where they experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or threat of physical harm to self or others. The individual's response involved intense fear, helplessness or horror (in children this may be expressed by disorganized or agitated behaviors).
   - Symptoms

     Re-experiencing – In children, nightmares or repetitive play or drawings in which themes or aspects of trauma are expressed.
     Avoidance-of reminders of the event and numbing of general Responsiveness.
     Increased arousal – difficulty sleeping is common in children.

   - In general, girls are more symptomatic than boys.
   - Common traumatic events- Domestic violence, natural disaster, shootings.
   - Younger children have more avoidant symptoms; older children have more re-experiencing and increased arousal.

- **Police response to children or adolescents with anxiety disorders**
  a. Usually police come into contact with these children because of "out-of-control behavior" related to intense anxiety.
  b. Be reassuring, speak slowly and calmly.
  c. Give the child time to relax.
  d. Most of these children want relief and will accept help.
  e. Allow them to be in the company of someone familiar as you are questioning them.
  f. Suicide risk is increased with anxiety.

D. Mood Disorders

1. **Bipolar Disorder** – (covered in Overview of Mental Illness)
   - Mood disorder where there is or has been a manic episode.
   - In children and adolescents, irritability more common than euphoria
   - Most common symptoms
     High activity level; rapid speech; highly distractible; racing thoughts; hypersexuality (in children-profanity, sexual comments, masturbation; in adolescents-increased sexual activity); and risk taking (in children, fighting; in adolescents, wild driving).
   - First episode may be mania or depression.
   - 20-30% of youth with major depression go on to have manic episodes.
2. **Major Depression** (covered in Overview of Mental Illness)
   - Mood disorder characterized by depression or irritability (irritability is more common).
   - Common symptoms in children
     Anxiety – phobias.
     Somatic complaints – headaches and/or stomachaches.
     Behavioral problems- temper tantrums.
     Sleep/appetite disturbance.
     Suicidal thoughts or attempts.

- **Police response to children and adolescents with mood disorders**
  a. Usually police will come in contact with these children/adolescents because of dangerous behaviors to self/others.
  b. The manic child/adolescent may be speaking rapidly or make no sense.
  c. The depressed child/adolescent may be irritable, tearful or speak little.

d. Risk for suicide in both disorders. (In mania, may be more in form of self-endangering behaviors).
e. Consider strongly information provided by witness even if child/adolescent denying further suicidal thoughts.
f. Inquire whether child/adolescent is in current mental health treatment or on medication.

E. Schizophrenia (covered in Overview of Mental Illness)

- Disorder characterized by psychotic symptoms (hallucinations, delusions, illogical thinking).
- Onset most typically in the adolescent.
- Onset in childhood extremely uncommon and has relatively poor outcome.
- In childhood, auditory hallucinations may include command hallucinations or commenting about the child. May have to do with monsters. Magical thinking is common.
- Childhood schizophrenia occurs predominantly in males.

- **Police response to child/adolescent with schizophrenia**:
  a. Usually will come in contact with these adolescents because of odd or agitated behavior.
  b. These children/adolescents may be paranoid of the police.
  c. Reassure them you want to help, you do not want them harmed and will do all you can to keep them safe.
  d. They may become combative.
  e. They may be talking to themselves. Don't challenge nor accept their delusions, just listen matter-of-factly.

B. Legal Issues

1. Consent to psychiatric or chemical dependency treatment.
   In Oregon a minor 14 years or older may consent for their own mental health, alcohol or drug treatment, excluding methadone. Parent/guardian can be advised of treatment when disclosure is clinically appropriate and serves the best interest of the minor.
2. Drug Testing
   A child under 14 can be tested without their knowledge or consent.
3. Parental rights
   An order of sole custody of a child to one parent does not deprive the non-custodial parent of authorizing medical treatment for their child. Only terminated parental rights by a court order denies the parent of the ability to authorize treatment for their child.

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

NOTES

NOTES

PERSONALITY DISORDERS

Personality Disorders Training
Crisis Intervention training
Portland Police
5/18/00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment.

B. Types:

1. Cluster A Paranoid, Schizoid, Schizotypal,
   - odd or eccentric

2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic,
   - dramatic, emotional or erratic

3. Cluster C: Avoident, Dependent, Obsessive Compulsive
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

III. Management of Behavior

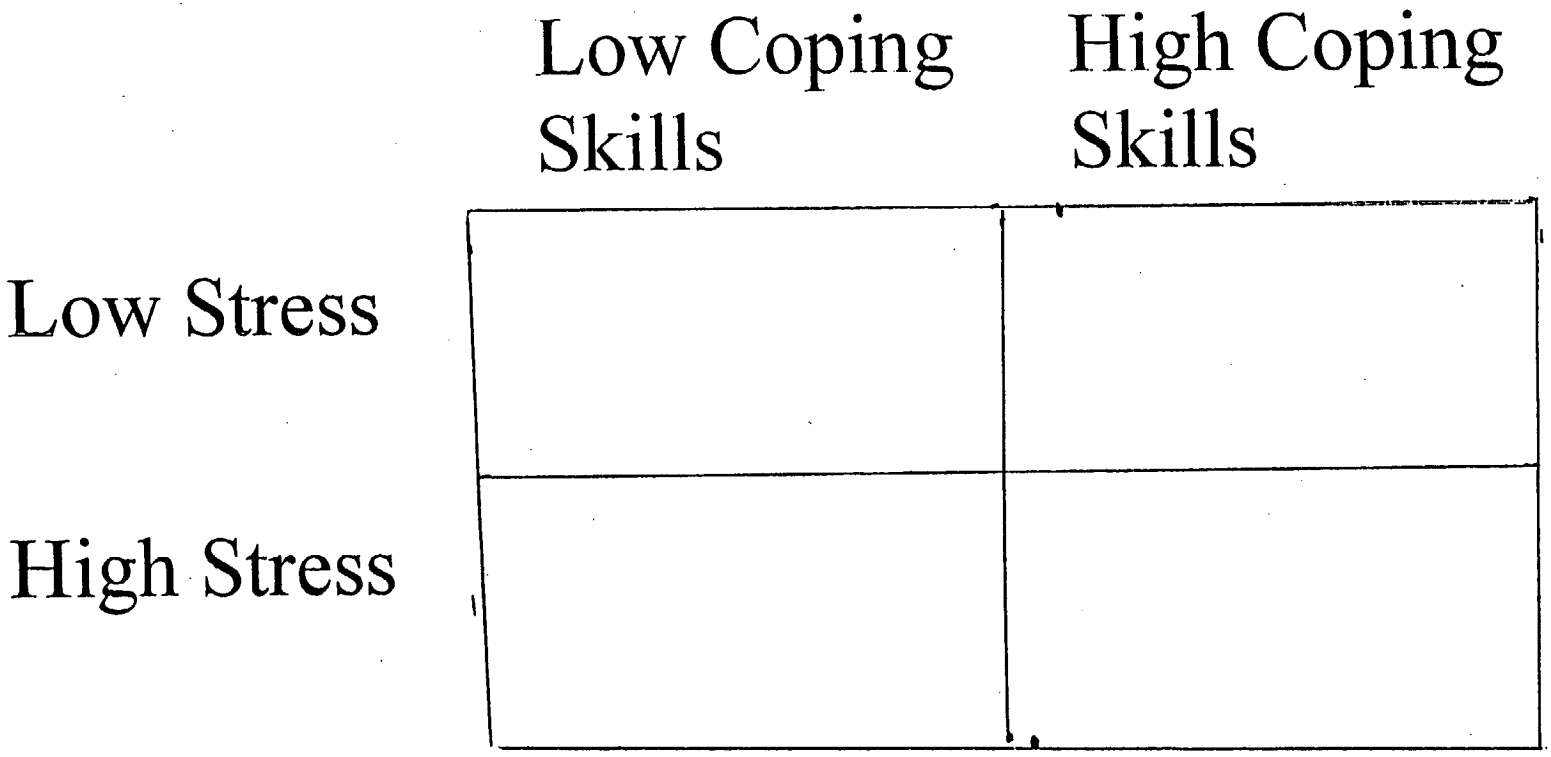
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



NOTES

POST TRAUMATIC

STRESS DISORDER

Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

<u>Additional Stressors of War</u>

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a rocket jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceiling just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

•

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

Trauma Recovery and Counseling Center
5999 Stevenson Avenue, Suite 404
Alexandria, Virgin
David P. Niles, EdD., CCMHC (703

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3976

Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker, RN

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
PORTLAND, OREGON 97204
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Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Sincerely,

Joe Parker, RN

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

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We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

   Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written <u>history</u> of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what <u>is</u> remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control <u>these</u> symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. <u>They do not provide a high, are not addicting, are legal, and are much safer than street drugs</u>.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb <u>hurts</u>. Being cut off from good things, including people, makes you <u>sad</u>.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really listen. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people may talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from hearing about what you had to live, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that learn, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be internal, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

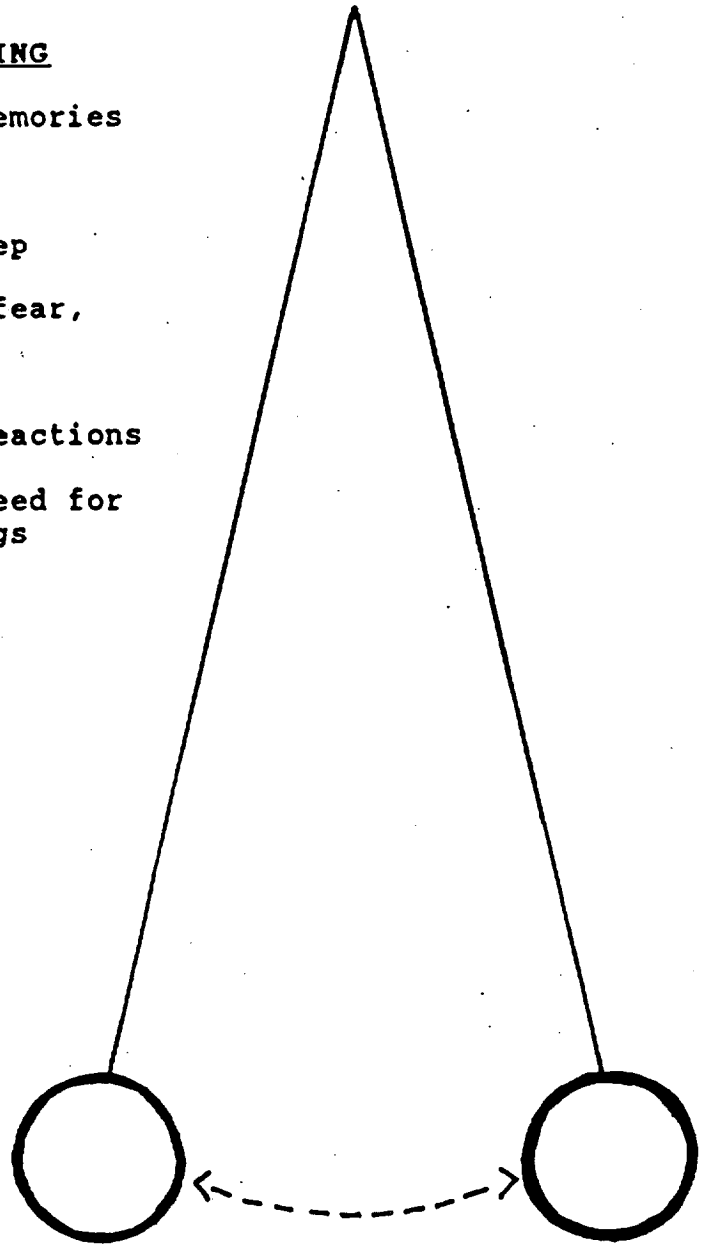
- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

- feeling nothing
- loss of normal interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

TOO AGITATED TO WORK ON PROBLEMS.

TOO MUCH ENERGY.



UNABLE TO HOPE FOR THINGS TO GET BETTER.

NOT ENOUGH ENERGY.

"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period

- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:

Lifetime Prevalence	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

Social:

- Means to behave like non-mentally ill peers
- Opportunities to be around others w/o high social demands
- Creates a sense of belonging to a social group

Self-Medication:

- Anxiety Reduction
- Improved ability to concentrate
- Improved energy level
- Increased sense of ability to function and well being
- Improved mood

Addiction:

- Physical and psychological dependence
- Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.

- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.

- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.

- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.

- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.

- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.

- Routes of administration can be oral, IV, intranasal, or through inhalation.

- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics*. They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks*. They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.

- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranoia.

- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.

- Acute mood changes, including euphoria, depression or irritability.

- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'

- Homelessness and itinerancy (frequent moving from place to place).

- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.

- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.

- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.

- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP		Sedative		Cocaine	Sedative Withdrawal
Cocaine		Stimulants		PCP	PCP Intoxication
Meth					Inhalant Intoxication
Inhalants					Cocaine Intoxication
*LSD					Brain Injuries

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritablity; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritablity; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual) synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

PROCEDURES

Section 2 – PROCEDURES

***Assessment Model**

***Mental Status Exam**

***Commitment Laws**

***Psychiatric Security Review Board**

***Consumer Rights / Rights of the Mentally Ill**

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

  feel - most commonly of bugs crawling on the body
  smell - often of gas associated with death plots
  taste - usually of poisons in food
  hearing - voices telling the person to do something
  sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

- Appearance

-- How is the individual dressed? Examples of dress which may indicate a mental illness include:

-- Inappropriate for weather (e.g. -- many layers in summer)
-- Inappropriate for context (e.g. -- pajamas in the street)
-- Odd or bizarre clothing
-- Very dirty/foul smelling/tattered clothing

-- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

-- Very dirty/foul smelling clothing
-- Very dirty/foul smelling body
-- Poor dental condition

-- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

-- Responding to internal stimuli (i.e. -- "talking to self")
-- Standing still/staring for prolonged periods (e.g. - catatonia)
-- Disorganized/non-goal directed actions
-- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
-- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
    -- plan
    -- access to enact plan
    -- intent to carry out plan
    -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
    -- memory (short, intermediate, and long term)
    -- concentration/distractibility
    -- abstract thoughts (often mentally ill individuals cannot think abstractly)

•Generalities

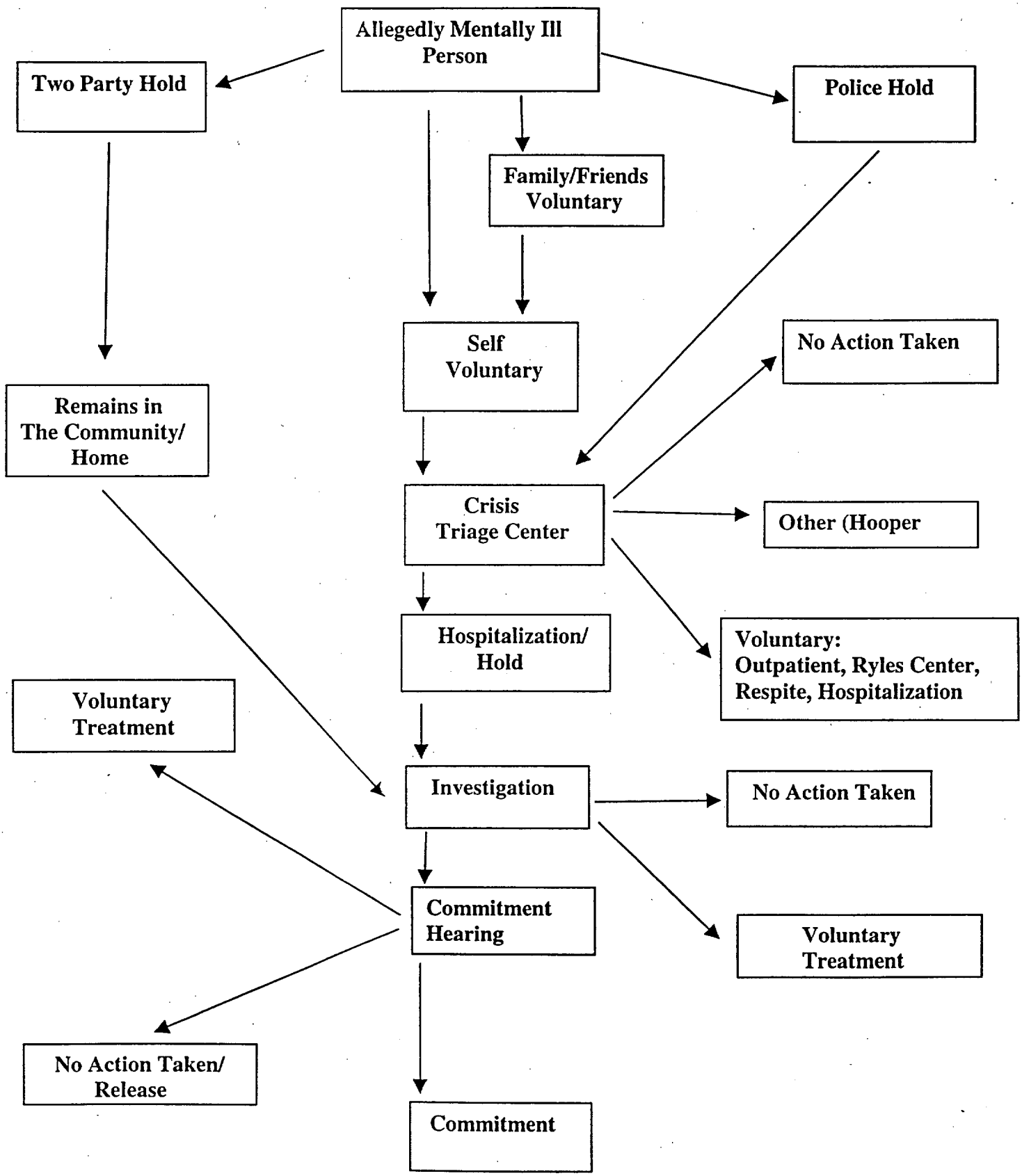
-- If it doesn't feel safe, don't do it!!
-- Mentally ill people are people, and deserve common respect.
-- Listen carefully.
-- Allow the individual to talk at length at least once.
-- Don't be afraid of silences. They often bring out symptoms.
-- Try to be an ally, not an adversary.

	Appearance	Thought Processes	Speech
Psychotic/Schizo -phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

COMMITMENT LAWS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility

AND

b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.

AND

c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

TITLE 35

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES; ALCOHOL AND DRUG ABUSE

Chapter 426

2001 EDITION

Persons with Mental Illness; Sexually Dangerous Persons

PERSONS WITH MENTAL ILLNESS

(Definitions)

426.005 Definitions for ORS 426.005 to 426.390. (1) As used in ORS 426.005 to 426.390, unless the context requires otherwise:

(a) "Department" means the Department of Human Services.

(b) "Director of the facility" means a superintendent of a state mental hospital, the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at other treatment facilities.

(c) "Facility" means a state mental hospital, community hospital, residential facility, detoxification center, day treatment facility or such other facility as the department determines suitable, any of which may provide diagnosis and evaluation, medical care, detoxification, social services or rehabilitation for committed mentally ill persons.

(d) "Mentally ill person" means a person who, because of a mental disorder, is one or more of the following:

(A) Dangerous to self or others.

(B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

(C) A person who:

(i) Is chronically mentally ill, as defined in ORS 426.495;

(ii) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the department under ORS 426.060;

(iii) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in subsubparagraph (ii) of this subparagraph; and

(iv) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become a person described under either or both subparagraph (A) or (B) of this paragraph.

(e) "Nonhospital facility" means any facility, other than a hospital, that is approved by the department to provide adequate security, psychiatric, nursing and other services to persons under ORS 426.232 or 426.233.

(f) "Prehearing period of detention" means a period of time calculated from the initiation of custody during which a person may be detained under ORS 426.228, 426.231, 426.232 or 426.233.

(2) Whenever a community mental health and developmental disabilities program director, director of the facility, superintendent of a state hospital or administrator of a facility is referred to, the reference includes any designee such person has designated to act on the person's behalf in the exercise of duties. [1961 c.706 §25; 1973 c.838 §1; 1987 c.903 §5; 1989 c.993 §3; 1993 c.484 §11; 2001 c.900 §125]

(Hospitals)

426.010 State hospitals for mentally ill persons. Except as otherwise ordered by the Department of Human Services pursuant to ORS 179.325, the Oregon State Hospital in Salem, Marion County, and the Eastern Oregon Psychiatric Center in Pendleton, Umatilla County, shall be used as state hospitals for the care and treatment of mentally ill persons who are assigned to the care of such institutions by the department or who have previously been committed to such institutions. [Amended by 1955 c.651 §3; 1965 c.339 §23; 1965 c.595 §2; 1983 c.505 §1; 1999 c.983 §6]

426.020 Superintendents; chief medical officer. The superintendents of the hospitals mentioned in ORS 426.010 shall be persons the Department of Human Services considers qualified to administer the hospital. If the superintendent of any hospital is a physician licensed by the Board of Medical Examiners for the State of Oregon, the superintendent shall serve as chief medical officer. If the superintendent is not a physician, the assistant director or the designee of the assistant director shall appoint a physician to serve as chief medical officer who shall be in the unclassified service. [Amended by 1955 c.651 §4; 1969 c.391 §1; 1973 c.807 §2; 1987 c.158 §76]

426.030 [Amended by 1955 c.651 §5; 1957 c.43 §1; repealed by 1999 c.983 §7]

426.060 Commitment to Department of Human Services; authority of department to direct placement; transfer authority; delegation. (1) Commitments to the Department of Human Services shall be made only by the judge of a circuit court in a county of this state.

(2) The following is a nonexclusive list of powers the department may exercise concerning the placement of persons committed or persons receiving emergency care and treatment under ORS 426.070, 426.228 to 426.235 or 426.237:

(a) In its discretion and for reasons which are satisfactory to the department, the department may direct any court committed person to the facility best able to treat the person. The authority of the department on such matters shall be final.

(b) At any time, for good cause and in the best interest of the mentally ill person, the department may transfer a committed person from one facility to another. When

transferring a person under this paragraph, the department shall make the transfer:

(A) If the transfer is from a facility in one class to a facility of the same class, as provided by rule of the department;

(B) If the transfer is from a facility in one class to a facility in a less restrictive class, by following the procedures for trial visits under ORS 426.273; and

(C) If the transfer is from a facility in one class to a facility in a more restrictive class, by following the procedures under ORS 426.275.

(c) At any time, for good cause and in the best interest of the mentally ill person, the department may transfer a person receiving emergency care and treatment under ORS 426.070 or 426.228 to 426.235, or intensive treatment under ORS 426.237, between hospitals and nonhospital facilities approved by the department to provide emergency care or treatment as defined by rule of the department.

(d) Pursuant to its rules, the department may delegate to a community mental health and developmental disabilities program director the responsibility for assignment of mentally ill persons to suitable facilities or transfer between such facilities under conditions which the department may define. [Amended by 1955 c.651 §6; 1963 c.254 §1; 1967 c.534 §19; 1973 c.838 §2; 1975 c.690 §1; 1987 c.903 §6; 1993 c.484 §12]

(Commitment Procedure)

426.070 Initiation; notification required; recommendation to court; citation. (1) Any of the following may initiate commitment procedures under this section by giving the notice described under subsection (2) of this section:

(a) Two persons;

(b) The county health officer; or

(c) Any magistrate.

(2) For purposes of subsection (1) of this section, the notice must comply with the following:

(a) It must be in writing under oath;

(b) It must be given to the community mental health and developmental disabilities program director or a designee of the director in the county where the allegedly mentally ill person resides;

(c) It must state that a person within the county other than the person giving the notice is a mentally ill person and is in need of treatment, care or custody;

(d) If the commitment proceeding is initiated by two persons under subsection (1)(a) of this section, it may include a request that the court notify the two persons:

(A) Of the issuance or nonissuance of a warrant under this section; or

(B) Of the court's determination under ORS 426.130 (1); and

(e) If the notice contains a request under paragraph (d) of this subsection, it must also include the addresses of the two persons making the request.

(3) Upon receipt of a notice under subsections (1) and (2) of this section or when notified by a circuit court that the court received notice under ORS 426.234, the community mental health and developmental disabilities program director, or designee of the director, shall:

(a) Immediately notify the judge of the court having jurisdiction for that county under ORS 426.060 of the notification described in subsections (1) and (2) of this section.

(b) Immediately notify the Department of Human Services if commitment is proposed because the person appears to be a mentally ill person, as defined in ORS 426.005 (1)(d)(C). When such notice is received, the department may verify, to the extent known by the department, whether or not the person meets the criteria described in ORS 426.005 (1)(d)(C)(i) and (ii) and so inform the director or designee of the director.

(c) Initiate an investigation under ORS 426.074 to determine whether there is probable cause to believe that the person is in fact a mentally ill person.

(4) Upon completion, a recommendation based upon the investigation report under ORS 426.074 shall be promptly submitted to the court. If the community mental health and developmental disabilities program director determines that probable cause does not exist to believe that a person released from detention under ORS 426.234 (2)(c) or (3)(b) is a mentally ill person, the community mental health and developmental disabilities program director shall not submit a recommendation to the court.

(5) When the court receives notice under subsection (3) of this section:

(a) If the court, following the investigation, concludes that there is probable cause to believe that the person investigated is a mentally ill person, it shall, through the issuance of a citation as provided in ORS 426.090, cause the person to be brought before it at a time and place as it may direct, for a hearing under ORS 426.095 to determine whether the person is mentally ill. The person shall be given the opportunity to appear voluntarily at the hearing unless the person fails to appear or unless the person is detained pursuant to paragraph (b) of this subsection.

(b)(A) The judge may cause the allegedly mentally ill person to be taken into custody pending the investigation or hearing by issuing a warrant of detention under this subsection. A judge may only issue a warrant under this subsection if the court finds that there is probable cause to believe that failure to take the person into custody would pose serious harm or danger to the person or to others.

(B) To cause the custody of a person under this paragraph, the judge must issue a warrant of detention to the community mental health and developmental disabilities program director or designee, the sheriff of the county or designee, directing that person to take the allegedly mentally ill person into custody and produce the person at the time and place stated in the warrant.

(C) At the time the person is taken into custody, the person shall be informed by the community mental health and developmental disabilities program director, the sheriff or a designee of the following:

(i) The person's rights with regard to representation by or appointment of counsel as described in ORS 426.100; and

(ii) The warning under ORS 426.123.

(D) The court may make any orders for the care and custody of the person prior to the hearing as it considers necessary.

(c) If the notice includes a request under subsection (2)(d)(A) of this section, the court shall notify the two persons of the issuance or nonissuance of a warrant under this subsection. [Amended by 1957 c.329 §1; 1967 c.534 §20; 1973 c.838 §3; 1975 c.690 §2; 1979 c.408 §1; 1983 c.740 §149; 1987 c.903 §7; 1989 c.993 §4; 1993 c.484 §26; 1995 c.201 §2; 1995 c.498 §1]

426.072 Custody; care; responsibilities of treating physician; rules. (1) A hospital or nonhospital facility and a treating physician must comply with the following when an allegedly mentally ill person is placed in custody at the hospital or nonhospital facility:

(a) By a warrant of detention under ORS 426.070;

(b) By a peace officer under ORS 426.228 or other person authorized under ORS 426.233; or

(c) By a physician under ORS 426.232.

(2) In circumstances described under subsection (1) of this section, the hospital or nonhospital facility and treating physician must comply with the following:

(a) The person shall receive the care, custody and treatment required for mental and physical health and safety;

(b) The treating physician shall report any care, custody and treatment to the court as required in ORS 426.075;

(c) All methods of treatment, including the prescription and administration of drugs, shall be the sole responsibility of the treating physician. However, the person shall not be subject to electro-shock therapy or unduly hazardous treatment and shall receive usual and customary treatment in accordance with medical standards in the community;

(d) The treating physician shall be notified immediately of any use of mechanical restraints on the person. Every use of a mechanical restraint and the reasons therefor shall be made a part of the clinical record of the person over the signature of the treating physician; and

(e) The treating physician shall give the person the warning under ORS 426.123 at times the treating physician determines the person will reasonably understand the notice. This paragraph only requires the notice to be given as often as the physician determines is necessary to assure that the person is given an opportunity to be aware of the notice.

(3) The Department of Human Services shall adopt rules necessary to carry out this section, including rules regarding the content of the medical record compiled during the current period of custody. [1987 c.903 §9; 1993 c.484 §13; 1997 c.531 §1]

426.074 Investigation; procedure; content; report. The following is applicable to an investigation initiated by a community mental health and developmental disabilities program director, or a designee of the director, as part of commitment procedures under ORS 426.070 and 426.228 to 426.235:

(1) If the allegedly mentally ill person is held in custody before the hearing the investigation shall be completed at least 24 hours before the hearing under ORS 426.095, otherwise the investigation shall comply with the following time schedule:

(a) If the allegedly mentally ill person can be located, the investigator shall contact the person within three judicial days from the date the community mental health and developmental disabilities program director or a designee receives a notice under ORS 426.070 alleging that the person is mentally ill.

(b) Within 15 days from the date the community mental health and developmental disabilities program director or a designee receives a notice under ORS 426.070 alleging that a person is mentally ill, one of the following shall occur:

(A) The investigation shall be completed and submitted to the court.

(B) An application for extension shall be made to the court under paragraph (c) of this subsection.

(c) The community mental health and developmental disabilities program director, a designee or the investigator may file for an extension of the time under paragraph (b) of this subsection only if one of the following occurs:

(A) A treatment option less restrictive than involuntary in-patient commitment is actively being pursued.

(B) The allegedly mentally ill person cannot be located.

(d) A court may grant an extension under paragraph (c) of this subsection for a time and upon the terms and conditions the court considers appropriate.

(2) This subsection establishes a nonexclusive list of provisions applicable to the content of the investigation, as follows:

(a) The investigation conducted should, where appropriate, include an interview or examination of the allegedly mentally ill person in the home of the person or other place familiar to the person.

(b) Whether or not the allegedly mentally ill person consents, the investigation should include interviews with any persons that the investigator has probable cause to believe have pertinent information regarding the investigation. If the allegedly mentally ill person objects to the contact with any person, the objection shall be noted in the investigator's report.

(c) The investigator shall be allowed access to physicians, nurses or social workers and to medical records compiled during the current involuntary prehearing period of detention to determine probable cause and to develop alternatives to commitment. If commitment is proposed because the person appears to be a mentally ill person as defined in ORS 426.005 (1)(d)(C), the investigator shall be allowed access to medical records necessary to verify the existence of criteria described in ORS 426.005 (1)(d)(C). The investigator shall include pertinent parts of the medical record in the investigation report. Records and communications described in this paragraph and communications related thereto are not privileged under ORS 40.230, 40.235, 40.240 or 40.250.

(3) A copy of the investigation report shall be provided as soon as possible, but in no event later than 24 hours prior to the hearing, to the allegedly mentally ill person and to that person's counsel. Copies shall likewise be provided to counsel assisting the court, to the examiners and to the court for use in questioning witnesses. [1987 c.903 §10; 1989 c.993 §5; 1993 c.484 §14; 1997 c.649 §1]

426.075 Notice and records of treatment prior to hearing; procedures. This section establishes procedures that are required to be followed before the hearing if a court, under ORS 426.070, orders a hearing under ORS 426.095. The following apply as described:

(1) The court shall be fully advised of all drugs and other treatment known to have been administered to the allegedly mentally ill person that may substantially affect the ability of the person to prepare for or function effectively at the hearing. The following shall advise the court as required by this subsection:

(a) When not otherwise provided by paragraph (b) of this subsection, the community mental health and developmental disabilities program director or designee.

(b) When the person has been detained by a warrant of detention under ORS 426.070, 426.180, 426.228, 426.232 or 426.233, the treating physician.

(2) The court shall appoint examiners under ORS 426.110 sufficiently long before the hearing so that they may begin their preparation for the hearing. The records established by the Department of Human Services by rule and the investigation report shall be made available to the examiners at least 24 hours before the hearing in order that the examiners may review the medical record and have an opportunity to inquire of the medical personnel concerning the treatment of the allegedly mentally ill person relating to the detention period prior to the hearing.

(3) The medical record described in subsection (2) of this section shall be made available to counsel for the allegedly mentally ill person at least 24 hours prior to the hearing.

(4) When requested by a party to the action, the party's attorney shall subpoena physicians who are or have been treating the allegedly mentally ill person. Any treating physician subpoenaed under this subsection shall be subpoenaed as an expert witness. [1973 c.838 §8; 1975 c.690 §3; 1979 c.408 §2; 1987 c.903 §12; 1989 c.189 §1; 1993 c.484 §15]

426.080 Execution and return of citation or warrant of detention. The person serving a warrant of detention or the citation provided for by ORS 426.090 shall, immediately after service thereof, make a return upon the original warrant or citation showing the time, place and manner of such service and file it with the clerk of the court. In executing the warrant of detention or citation, the person has all the powers provided by ORS 133.235 and 161.235 to 161.245 and may require the assistance of any peace

officer or other person. [Amended by 1971 c.743 §366; 1973 c.836 §348; 1973 c.838 §4a]

426.090 Citation; service. The judge shall cause a citation to issue to the allegedly mentally ill person stating the nature of the information filed concerning the person and the specific reasons the person is believed to be mentally ill. The citation shall further contain a notice of the time and place of the commitment hearing, the right to legal counsel, the right to have legal counsel appointed if the person is unable to afford legal counsel, and, if requested, to have legal counsel immediately appointed, the right to subpoena witnesses in behalf of the person to the hearing and other information as the court may direct. The citation shall be served upon the person by delivering a duly certified copy of the original thereof to the person in person prior to the hearing. The person shall have an opportunity to consult with legal counsel prior to being brought before the court. [Amended by 1957 c.329 §2; 1967 c.459 §1; 1971 c.368 §1; 1973 c.838 §5; 1975 c.690 §4]

426.095 Commitment hearing; postponement; right to cross-examine; admissibility of investigation report. The following is applicable to a commitment hearing held by a court under ORS 426.070:

(1) The hearing may be held in a hospital, the person's home or in some other place convenient to the court and the allegedly mentally ill person.

(2) The court shall hold the hearing at the time established according to the following:

(a) Except as provided by paragraph (b) or (c) of this subsection, a hearing shall be held five judicial days from the day a court under ORS 426.070 issues a citation provided under ORS 426.090.

(b) Except as provided by paragraph (c) of this subsection, if a person is detained by a warrant of detention under ORS 426.070, a hearing shall be held within five judicial days of the commencement of detention.

(c) If requested under this paragraph, the court, for good cause, may postpone the hearing for not more than five judicial days in order to allow preparation for the hearing. The court may make orders for the care and custody of the person during a postponement as it deems necessary. If a person is detained before a hearing under ORS 426.070, 426.180, 426.228, 426.232 or 426.233 and the hearing is postponed under this paragraph, the court, for good cause, may allow the person to be detained during the postponement if the postponement is requested by the person or the legal counsel of the person. Any of the following may request a postponement under this paragraph:

(A) The allegedly mentally ill person.

(B) The legal counsel or guardian of the allegedly mentally ill person.

(C) The person representing the state's interest.

(3) The allegedly mentally ill person and the person representing the state's interest shall have the right to cross-examine all the following:

(a) Witnesses.

(b) The person conducting the investigation.

(c) The examining physicians or other qualified persons recommended by the Department of Human Services who have examined the person.

(4) The provisions of ORS 40.230, 40.235, 40.240 and 40.250 shall not apply to and the court may consider as evidence any of the following:

(a) Medical records for the current involuntary prehearing period of detention.

(b) Statements attributed by the maker of the medical records or the investigation report to witnesses concerning their own observations in the absence of objection or if such persons are produced as witnesses at the hearing available for cross-examination.

(c) The testimony of any treating physicians, nurses or social workers for the prehearing period of detention. Any treating physician, nurse or social worker who is subpoenaed as a witness for the proceeding shall testify as an expert witness under the provisions of ORS 40.410, 40.415, 40.420 and 40.425 and is subject to treatment as an expert witness in the payment of witness fees and costs.

(d) The investigation report prepared under ORS 426.074. Subject to the following, the investigation report shall be introduced in evidence:

(A) Introduction of the report under this paragraph does not require the consent of the allegedly mentally ill person.

(B) Upon objection by any party to the action, the court shall exclude any part of the investigation report that may be excluded under the Oregon Evidence Code on grounds other than those set forth in ORS 40.230, 40.235, 40.240 or 40.250.

(C) Neither the investigation report nor any part thereof shall be introduced into evidence under this paragraph unless the investigator is present during the proceeding to be cross-examined or unless the presence of the investigator is waived by the allegedly mentally ill person or counsel for the allegedly mentally ill person. [1973 c.838 §9; 1975 c.690 §5; 1987 c.903 §13; 1993 c.484 §16; 1997 c.649 §2]

426.100 Advice of court; appointment of legal counsel; fee; representation of state's interest. (1) At the time the allegedly mentally ill person is brought before the court, the court shall advise the person of the following:

(a) The reason for being brought before the court;

(b) The nature of the proceedings;

(c) The possible results of the proceedings;

(d) The right to subpoena witnesses; and

(e) The person's rights regarding representation by or appointment of counsel.

(2) Subsection (3) of this section establishes the rights of allegedly mentally ill persons in each of the following circumstances:

(a) When the person is held by warrant of detention issued under ORS 426.070.

(b) In commitment hearings under ORS 426.095.

(c) When the person is detained as provided under ORS 426.228, 426.232 or 426.233.

(d) In recommitment hearings under ORS 426.307.

(3) When provided under subsection (2) of this section, an allegedly mentally ill person has the following rights relating to representation by or appointment of counsel:

(a) The right to obtain suitable legal counsel possessing skills and experience commensurate with the nature of the allegations and complexity of the case during the proceedings.

(b) If the person does not have funds with which to retain legal counsel, the court will appoint legal counsel to represent the person without cost. If a person is unable to afford legal counsel, payment of expenses and compensation relating to legal counsel shall be made as provided under ORS 426.250.

(c) If the allegedly mentally ill person does not request legal counsel, the legal guardian, relative or friend may request the assistance of suitable legal counsel on behalf of the person.

(d) If no request for legal counsel is made, the court shall appoint suitable legal counsel unless counsel is expressly, knowingly and intelligently refused by the person.

(e) If the person is being involuntarily detained before a hearing on the issue of commitment, the right under paragraph (a) of this subsection to contact an attorney or under paragraph (b) of this subsection to have an attorney appointed may be exercised as soon as reasonably possible.

(f) In all cases suitable legal counsel shall be present at the hearing and may be present at examination and may examine all witnesses offering testimony, and otherwise represent the person.

(4) The responsibility for representing the state's interest in commitment proceedings, including, but not limited to, preparation of the state's case and appearances at commitment hearings is as follows:

(a) The Attorney General's office shall have the responsibility relating to proceedings initiated by state hospital staff that are any of the following:

(A) Recommitment proceedings under ORS 426.307; or

(B) Proceedings under ORS 426.228, 426.232 or 426.233.

(b) The district attorney if requested to do so by the governing body of the county.

(c) In lieu of the district attorney under paragraph (b) of this subsection, a counsel designated by the governing body of a county shall take the responsibility. A county governing body may designate counsel to take responsibility under this paragraph either for single proceedings or for all such proceedings the county will be obligated to pay for under ORS 426.250. If a county governing body elects to proceed under this paragraph, the county governing body shall so notify the district attorney. The expenses of an attorney appointed under this paragraph shall be paid as provided under ORS 426.250. [Amended by 1967 c.458 §1; 1971 c.368 §2; 1973 c.838 §6; 1975 c.690 §6; 1977 c.259 §1; 1979 c.574 §§1,2; 1979 c.867 §10; 1981 s.s. c.3 §133; 1987 c.903 §14; 1993 c.484 §17]

Note: The amendments to 426.100 by section 57, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.100. (1) At the time the allegedly mentally ill person is brought before the court, the court shall advise the person of the following:

(a) The reason for being brought before the court;

(b) The nature of the proceedings;

(c) The possible results of the proceedings;

(d) The right to subpoena witnesses; and

(e) The person's rights regarding representation by or appointment of counsel.

(2) Subsection (3) of this section establishes the rights of allegedly mentally ill persons in each of the following circumstances:

(a) When the person is held by warrant of detention issued under ORS 426.070.

(b) In commitment hearings under ORS 426.095.

(c) When the person is detained as provided under ORS 426.228, 426.232 or 426.233.

(d) In recommitment hearings under ORS 426.307.

(3) When provided under subsection (2) of this section, an allegedly mentally ill person has the following rights relating to representation by or appointment of counsel:

(a) The right to obtain suitable legal counsel possessing skills and experience commensurate with the nature of the allegations and complexity of the case during the proceedings.

(b) If the person is determined to be financially eligible for appointed counsel at state expense, the court will appoint legal counsel to represent the person. If a person is appointed counsel at state expense, payment of expenses and compensation relating to legal counsel shall be made as provided under ORS 426.250.

(c) If the allegedly mentally ill person does not request legal counsel, the legal guardian, relative or friend may request the assistance of suitable legal counsel on behalf of the person.

(d) If no request for legal counsel is made, the court shall appoint suitable legal counsel unless counsel is expressly, knowingly and intelligently refused by the person.

(e) If the person is being involuntarily detained before a hearing on the issue of commitment, the right under paragraph (a) of this subsection to contact an attorney or under paragraph (b) of this subsection to have an attorney appointed may be exercised as soon as reasonably possible.

(f) In all cases suitable legal counsel shall be present at the hearing and may be present at examination and may examine all witnesses offering testimony, and otherwise represent the person.

(4) The responsibility for representing the state's interest in commitment proceedings, including, but not limited to, preparation of the state's case and appearances at commitment hearings is as follows:

(a) The Attorney General's office shall have the responsibility relating to proceedings initiated by state hospital staff that are any of the following:

(A) Recommitment proceedings under ORS 426.307; or

(B) Proceedings under ORS 426.228, 426.232 or 426.233.

(b) The district attorney if requested to do so by the governing body of the county.

(c) In lieu of the district attorney under paragraph (b) of this subsection, a counsel designated by the governing body of a county shall take the responsibility. A county governing body may designate counsel to take responsibility under this paragraph either for single proceedings or for all such proceedings the county will be obligated to pay for under ORS 426.250. If a county governing body elects to proceed under this paragraph, the county governing body shall so notify the district attorney. The expenses of an attorney appointed under this paragraph shall be paid as provided under ORS 426.250.

426.110 Appointment of examiners; qualifications; fees. The following requirements relating to the appointment of examiners for purposes of a hearing under ORS 426.095 apply as described:

(1) The judge shall appoint one qualified examiner. If requested, the judge shall appoint one additional qualified examiner. A request for an additional examiner under this subsection must be made in writing and must be made by the allegedly mentally ill person or the attorney for the allegedly mentally ill person.

(2) To be qualified for purposes of this section, an examiner must meet all of the following qualifications:

(a) The person must agree to be an examiner.

(b) The person must be one of the following:

(A) A physician licensed by the Board of Medical Examiners for the State of Oregon who is competent to practice psychiatry as provided by the Department of Human Services by rule.

(B) Certified as a mental health examiner qualified to make examinations for involuntary commitment proceedings by the department. The department has authority to establish, by rule, requirements for certification as a mental health examiner for purposes of this subparagraph.

(3) The cost of examiners under this section shall be paid as provided under ORS 426.250. [Amended by 1973 c.838 §10; 1987 c.158 §77; 1987 c.903 §15]

426.120 Examination report; rules. (1) Persons appointed under ORS 426.110 to conduct the examination shall do the following:

(a) Examine the person as to mental condition;

(b) Initiate the examination process prior to the hearing. Any failure to comply with this paragraph shall not, in itself, constitute sufficient grounds to challenge the examination conducted by an examiner;

(c) Make their separate reports in writing, under oath, to the court; and

(d) Upon completion of the hearing, file the reports with the clerk of the court.

(2) The following is a nonexclusive list of requirements relating to the content of examination reports prepared under subsection (1) of this section:

(a) If the examining persons find, and show by their reports, that the person examined is a mentally ill person, the reports shall include a recommendation as to the type of treatment facility best calculated to help the person recover from mental illness.

(b) Each report shall also advise the court whether in the opinion of the examiner the mentally ill person would cooperate with and benefit from a program of voluntary treatment.

(c) Reports shall contain the information required by the Department of Human Services by rule. The department shall adopt rules necessary to carry out this paragraph.

(3) The examiner shall be allowed access to physicians, nurses or social workers and to medical records compiled during the current involuntary prehearing period of detention and the investigation report. Records and communications described in this sub-

section and communications related thereto are not privileged under ORS 40.230, 40.235, 40.240 or 40.250. [Amended by 1973 c.838 §11; 1975 c.690 §7; 1987 c.903 §16; 1997 c.649 §3]

426.123 Observation of person in custody; warning; evidence. (1) Whenever specifically required under ORS 426.070, 426.072, 426.180 or 426.234, a person shall be given a warning that observations of the person by the staff of the facility where the person is in custody may be used as evidence in subsequent court proceedings to determine whether the person should be or should continue to be committed as a mentally ill person.

(2) The warning described under subsection (1) of this section shall be given both orally and in writing.

(3) Failure to give a warning under this section does not in itself constitute grounds for the exclusion of evidence that would otherwise be admissible in a proceeding. [1987 c.903 §11; 1993 c.484 §18]

426.125 Qualifications and requirements for conditional release. The following qualifications, requirements and other provisions relating to a conditional release under ORS 426.130 apply as described:

(1) A court may only order conditional release if all of the following occur:

(a) The conditional release is requested by the legal guardian, relative or friend of the mentally ill person.

(b) The person requesting the conditional release requests to be allowed to care for the mentally ill person during the period of commitment in a place satisfactory to the judge.

(c) The person requesting the release establishes all of the following to the satisfaction of the court:

(A) Ability to care for the mentally ill person.

(B) That there are adequate financial resources available for the care of the mentally ill person.

(2) If the court determines to allow conditional release, the court shall order that the mentally ill person be conditionally released and placed in the care of the requester. The court shall establish any terms and conditions on the conditional release that the court determines appropriate.

(3) Any conditional release ordered under this section is subject to the provisions under ORS 426.275. [1987 c.903 §18]

426.127 Outpatient commitment. The following provisions are applicable to outpatient commitment under ORS 426.130 as described:

(1) The Department of Human Services may only place a person in an outpatient commitment if an adequate treatment facility is available.

(2) Conditions for the outpatient commitment shall be set at the time of the hearing under ORS 426.095 by the community mental health and developmental disabilities program director, or a designee for the director, for the county in which the hearing takes place. The conditions shall include, but not be limited to, the following:

(a) Provision for outpatient care.

(b) A designation of a facility, service or other provider to provide care or treatment.

(3) A copy of the conditions shall be given to all of the persons described in ORS 426.278.

(4) Any outpatient commitment ordered under this section is subject to the provisions under ORS 426.275.

(5) The community mental health and developmental disabilities program director or designee, for the county where a person is on outpatient commitment, may modify the conditions for outpatient commitment when a modification is in the best interest of the person. The director or designee shall send notification of such changes and the reasons for the changes to all those who received a copy of the original conditions under ORS 426.278. [1987 c.903 §19; 1989 c.171 §52]

426.130 Court determination of mental illness; discharge; release for voluntary treatment; conditional release; commitment; prohibition relating to firearms; period of commitment. (1) After hearing all of the evidence, and reviewing the findings of the examining persons, the court shall determine whether the person is mentally ill. If, in the opinion of the court, the person is:

(a) Not mentally ill, the person shall be discharged forthwith.

(b) Mentally ill based upon clear and convincing evidence, the court:

(A) Shall order the release of the individual and dismiss the case if:

(i) The mentally ill person is willing and able to participate in treatment on a voluntary basis; and

(ii) The court finds that the person will probably do so.

(B) May order conditional release under this subparagraph subject to the qualifications and requirements under ORS 426.125. If the court orders conditional release under this subparagraph, the court shall establish a period of commitment for the conditional release.

(C) May order commitment of the individual to the Department of Human Services for treatment if, in the opinion of the court, subparagraph (A) or (B) of this paragraph is not in the best interest of the mentally ill person. If the court orders commitment under this subparagraph:

(i) The court shall establish a period of commitment.

(ii) The department may place the committed person in outpatient commitment under ORS 426.127.

(D) Shall order that the person be prohibited from purchasing or possessing a firearm if, in the opinion of the court, there is a reasonable likelihood the person would constitute a danger to self or others or to the community at large as a result of the person's mental or psychological state as demonstrated by past behavior or participation in incidents involving unlawful violence or threats of unlawful violence, or by reason of a single incident of extreme, violent, unlawful conduct. When a court makes an order under this subparagraph, the court shall cause a copy of the order to be delivered to the sheriff of the county who will enter the information into the Law Enforcement Data System.

(2) A court that orders a conditional release or a commitment under this section shall establish a period of commitment for the person subject to the order. Any period of commitment ordered for commitment or conditional release under this section shall be for a period of time not to exceed 180 days.

(3) If the commitment proceeding was initiated under ORS 426.070 (1)(a) and if the notice included a request under ORS 426.070 (2)(d)(B), the court shall notify the two persons of the court's determination under subsection (1) of this section. [Amended by 1973 c.838 §12; 1975 c.690 §8; 1979 c.408 §3; 1987 c.903 §17; 1989 c.839 §36; 1993 c.735 §9; 1995 c.498 §2]

426.135 Counsel on appeal; costs of appeal. If a person determined to be mentally ill as provided in ORS 426.130 appeals the determination or disposition based thereon, and is unable to afford suitable legal counsel possessing skills and experience commensurate with the nature and complexity of the case to represent the person on appeal, the court, upon request of the person or upon its own motion, shall appoint suitable legal counsel to represent the person. The compensation for legal counsel and costs and expenses necessary to the appeal shall be determined and allowed by the appellate court as provided in ORS 135.055 if the circuit court is the appellate court or as provided in ORS 138.500 if the Court of Appeals or Supreme Court is the appellate court. The compensation, costs and expenses so allowed shall be paid as provided in ORS 138.500. [1979 c.867 §12; 1981 s.s. c.3 §134; 1985 c.502 §25]

Note: The amendments to 426.135 by section 58, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.135. If a person determined to be mentally ill as provided in ORS 426.130 appeals the determination or disposition based thereon, and is determined to be financially eligible for appointed counsel at state expense, upon request of the person or upon its own motion, the court shall appoint suitable legal counsel to represent the person. The compensation for legal counsel and costs and expenses necessary to the appeal shall be determined and paid by the public defense services executive director as provided in ORS 135.055 if the circuit court is the appellate court or as provided in ORS 138.500 if the Court of Appeals or Supreme Court is the appellate court. The compensation, costs and expenses shall be paid as provided in ORS 138.500.

426.140 Place of confinement; attendant. (1) No person, not incarcerated upon a criminal charge, who has been adjudged a mentally ill person or one against whom commitment proceedings have been instituted shall be confined in any prison, jail or other enclosure where those charged with a crime or a violation of a municipal ordinance are incarcerated, unless the person represents an immediate and serious danger to staff or physical facilities of a hospital or other facility approved by the Department of Human Services for the care, custody and treatment of the person.

(2) No allegedly mentally ill person who has been taken into custody shall be confined, either before or after the commitment hearing, without an attendant in direct charge of the person; and, if not confined in a community hospital, the sheriff or community mental health and developmental disabilities program director having the person in custody shall select some suitable person to act as attendant in quarters suitable for the comfortable, safe and humane confinement of the person and approved by the department. [Amended by 1973 c.838 §23; 1975 c.690 §9; 1977 c.764 §1]

426.150 Transportation to treatment facility. (1) Upon receipt of the order of commitment, the Department of Human Services or its designee shall take the mentally ill person into its custody, and insure the safekeeping and proper care of the person until delivery is made to an assigned treatment facility or its representative. The representative of the treating facility to which the person has been assigned, accompanied by any assistants the department or its designee may deem necessary, shall proceed to the place where the person is to be delivered into custody, and upon demand shall be given custody of the mentally ill person, together with the certified record required by ORS

426.170. The representative shall issue appropriate receipts therefor and immediately proceed to transport the committed mentally ill person safely to the facility to which the person has been assigned by the department and there make delivery of the person and the record to the director or a designated employee of the facility. In taking custody of the person, the department, its designee, or the representative of the facility has all the powers provided by ORS 133.225 and 161.255 and may require the assistance of any peace officer or other person.

(2) The committing judge, upon approval of the examining physicians or other qualified persons as recommended by the department and upon request of a guardian, friend or relative of the mentally ill person, may authorize the guardian, friend or relative to transport the person to the designated facility when the committing judge determines that means of transportation would not be detrimental to the welfare of the mentally ill person or to the public. [Amended by 1963 c.325 §1; 1973 c.838 §24; 1975 c.690 §10]

426.155 Release of information about person held in custody pending commitment proceeding or while committed or recommitted. (1) The provisions of this section apply to the release of information about a person who is held in custody either pending a commitment proceeding under ORS 426.070, 426.140, 426.228, 426.232, 426.233 or 426.237 (1)(b) or while committed or recommitted under ORS 426.005 to 426.390.

(2) Notwithstanding the provisions of ORS 179.495, 179.505 or 192.502 (2) and notwithstanding any other provision of ORS 426.005 to 426.390, a facility or nonhospital facility where a person is held shall establish procedures for releasing information as required under subsections (3) and (4) of this section.

(3)(a) If a person described in subsection (1) of this section authorizes disclosure as provided in subsection (5) of this section, upon request of a member of the family of the person, or any other person designated by the person, a facility or nonhospital facility where the person is held shall provide the family member or the designee with the following information:

(A) The person's diagnosis;

(B) The person's prognosis;

(C) The medications prescribed for the person and the side effects of medications prescribed, if any;

(D) The person's progress;

(E) Information about any civil commitment process, including the date, time and location of the person's commitment hearing; and

(F) Where and when the person may be visited.

(b) If a request for information is made under this subsection and the person described in subsection (1) of this section is unable to authorize disclosure as provided in subsection (5) of this section, the person requesting information shall be provided notice of the presence of the person described in subsection (1) of this section in any facility or nonhospital facility. Information shall not be provided under this paragraph if the physician of the person described in subsection (1) of this section determines that it would not be in the person's best interest to provide the information or if providing the information is prohibited by federal law.

(4) Upon the admission of any person to a facility or nonhospital facility under ORS 426.005 to 426.390, the facility or nonhospital facility shall make reasonable attempts to notify the person's next of kin, or any other person designated by the person, of the person's admission, unless the person requests that this information not be provided. The facility or nonhospital facility shall make reasonable attempts to notify the person's next of kin, or any other person designated by the person, of the person's release, transfer, serious illness, injury or death upon request of the family member or designee, unless the person requests that this information not be provided. The person shall be advised by the facility or nonhospital facility that the person has the right to request that this information not be provided.

(5) The person who is held in custody shall be notified by the facility or nonhospital facility that information about the person has been requested. Except as provided in subsection (3) of this section, the consent of the person who is held is required for release of information under subsections (3) and (4) of this section. If, when initially informed of the request for information, the person is unable to give voluntary and informed consent to authorize the release of information, notation of the attempt shall be made in the person's treatment record and daily efforts shall be made to secure the person's consent or refusal of authorization.

(6) Notwithstanding any other provision of this section, an individual eligible to receive information under subsection (3) of this section may not receive information unless the individual first agrees to make no further disclosure of the information. The agreement may be made orally.

(7) A facility or nonhospital facility that releases information under subsection (3) or (4) of this section shall:

(a) Notify the person who is held to whom, when and what information was released; and

(b) Note in the medical record of the person who is held:

(A) The basis for finding that the person gave voluntary and informed consent;

(B) The oral or written consent of the person who is held;

(C) To whom, when and what information was released;

(D) The agreement to the requirements of subsection (6) of this section by the person who requested information; and

(E) Any determination made by the person's physician under subsection (3)(b) of this section regarding the provision of notice of the presence of the person in any facility or nonhospital facility.

(8) A facility or nonhospital facility, including the staff of such facilities and nonhospital facilities, that releases information under this section or rules adopted under ORS 426.236 may not be held civilly or criminally liable for damages caused or alleged to be caused by the release of information or the failure to release information as long as the release was done in good faith and in compliance with subsections (3) and (4) of this section or rules adopted under ORS 426.236.

(9) The provisions of subsections (3) and (4) of this section do not limit the ability or obligation of facilities, nonhospital facilities, physicians, mental health care providers or licensed mental health professionals to provide information as otherwise allowed or required by law. [2001 c.481 §2]

Note: 426.155 was added to and made a part of 426.005 to 426.390 by legislative action but was not added to any other series therein. See Preface to Oregon Revised Statutes for further explanation.

426.160 Record of proceedings. The judge shall cause to be recorded in the court records a full account of proceedings had at all hearings and examinations conducted pursuant to ORS 426.005, 426.060 to 426.170, 426.217, 426.228, 426.255 to 426.292, 426.300 to 426.309, 426.385 and 426.395, together with the judgments and orders of the court and a copy of the orders issued. The account of the proceedings and transcripts of testimony if taken there at shall be delivered to the court clerk or court administrator who shall cause it to be sealed and neither the account of the proceedings nor the transcript of testimony if taken shall be disclosed to any person except:

(1) As provided in ORS 426.070 (5)(c), 426.130 (3) or 426.170;

(2) Upon request of the person subject to the proceedings, the legal representatives, or the attorney of the person; or

(3) Pursuant to court order. [Amended by 1965 c.420 §1; 1969 c.148 §1; 1973 c.838 §21; 1993 c.223 §11; 1993 c.484 §19; 1995 c.498 §3]

426.170 Delivery of certified copy of record. If any person is adjudged mentally ill and ordered committed to the Department of Human Services, a copy of the complete record in the case, certified to by the court clerk or court administrator, shall be given to the health officer of the county, or to the sheriff, for delivery to the director of the facility to which such mentally ill person is assigned. The record shall include the name, residence, nativity, sex and age of such mentally ill person and all other information that may be required by the rules and regulations promulgated by the department. [Amended by 1973 c.838 §25; 1993 c.223 §12]

426.175 [1969 c.371 §1; 1975 c.690 §11; 1977 c.764 §2; 1987 c.903 §20; 1991 c.901 §1; repealed by 1993 c.484 §27]

(Emergency and Voluntary Admissions)

426.180 Emergency commitment of certain Native Americans. (1) This section applies to commitments of a person from a reservation for land-based tribes of Native Americans when, under federal law, the state does not have jurisdiction of commitments on the reservation.

(2) When this section is applicable as provided under subsection (1) of this section, a person alleged to be mentally ill by affidavit of two other persons may be admitted to a state hospital for the mentally ill for emergency treatment, care and custody, provided such affidavit includes or is accompanied by all of the following:

(a) The circumstances constituting the emergency.

(b) Written application for admission to the hospital, executed in duplicate.

(c) A certificate to the effect that the person is so mentally ill as to be in need of immediate hospitalization.

(d) A medical history, including the name, condition, sex and age of the person.

(e) The name and address of the nearest relative or legal guardian, if any, of the person.

(3) The certificates, applications and medical histories shall be made upon forms prescribed by the Department of Human Services and shall be executed by the county health officer or by two physicians licensed by the Board of Medical Examiners, none of whom shall be related to the person by blood or marriage.

(4) When a person is admitted to a state hospital under this section, any physician treating the person shall give the person the warning under ORS 426.123.

(5) This section may be applied as provided by agreement with the ruling body of the reservation. Payment of costs for a commitment made under this section shall be as provided under ORS 426.250. [Amended by 1953 c.442 §2; 1975 c.690 §12; 1987 c.903 §21]

426.190 Admission on emergency commitment. Immediately upon execution of the documents mentioned in ORS 426.180, the person, together with the documents, shall be transported by the sheriff or other person on the authorization of the county health officers or deputy to the state hospital indicated by law to receive such patient. The chief medical officer of the state hospital may refuse to admit the person unless the chief medical officer is satisfied from the documents that an emergency exists, and that the person is so mentally ill as to be in need of immediate hospitalization. The superintendent shall file such documents in the office of the hospital, where they shall remain a matter of record. If the superintendent is satisfied that an emergency exists, and that such person is so mentally ill as to be in need of immediate hospitalization, the superintendent shall receive and care for as a patient in the hospital the person named in the documents. [Amended by 1969 c.391 §2]

426.200 Duties following emergency admission; application for voluntary admission; court commitment. Within 48 hours after admission under ORS 426.190, an examination as to the mental condition of any person so admitted shall be commenced and shall be conducted as expeditiously as possible by two staff physicians of the state hospital where the person has been received. If, after completion of the examination, the physicians certify that the person is so mentally ill as to be in need of treatment, care or custody, the superintendent shall, if the superintendent determines that further hospitalization is necessary, within 48 hours thereafter, either obtain from the mentally ill person a signed application for voluntary admission under the provisions of ORS 426.220 or file a complaint with the court having jurisdiction under ORS 426.060 in the county where the hospital is located, requesting a court commitment as provided by law. If the examining physicians certify that the person is not so mentally ill as to be in need of treatment, care or custody, the superintendent of the state hospital shall immediately discharge the person. Costs shall be paid as provided under ORS 426.250. [Amended by 1963 c.325 §2; 1975 c.690 §13; 1987 c.903 §22]

426.210 Limit of detention after commitment in emergency proceedings. In no event shall any person admitted to a state hospital pursuant to the emergency proceedings provided by ORS 426.180 to 426.200 be detained therein by virtue of such proceedings for more than five judicial days following admission. The court, for good cause, may allow a postponement and detention during the postponement as provided under ORS 426.095. [Amended by 1987 c.903 §23]

426.215 [1965 c.628 §1; 1973 c.838 §32; 1975 c.690 §14; 1977 c.764 §3; 1979 c.408 §4; 1985 c.743 §§1,2,3; 1987 c.368 §1; 1987 c.903 §§24,25; repealed by 1993 c.484 §27]

426.217 Change of status of committed patient to voluntary patient; effect of change. At any time after commitment by the court, the person, with the approval of the Department of Human Services or its designee, may change the status of the person to that of a voluntary patient. Notwithstanding ORS 426.220, any person who alters status to that of a voluntary patient under this section shall be released from the treating facility within 72 hours of the request of the person for release. [1973 c.838 §14; 1975 c.690 §15]

426.220 Voluntary admission; leave of absence; notice to parent or guardian. (1) Pursuant to rules and regulations promulgated by the Department of Human Services, the superintendent of any state hospital for the treatment and care of the mentally ill may admit and hospitalize therein as a patient, any person who may be suffering from nervous disorder or mental illness, and who voluntarily has made written application for such admission. No person under the age of 18 years shall be admitted as a patient to any such state hospital unless an application therefor in behalf of the person has been executed by the parent, adult next of kin or legal guardian of the person. Except when a period of longer hospitalization has been imposed as a condition of admission, pursuant to rules and regulations of the department, no person voluntarily admitted to any state hospital shall be detained therein more than 72 hours after the person, if at least 18 years of age, has given notice in writing of a desire to be discharged therefrom, or, if the patient is under the age of 18 years, after notice in writing has been given by the parent, adult next of kin or legal guardian of the person that such parent, adult next of kin or legal guardian desires that such person be discharged therefrom.

(2) Any person voluntarily admitted to a state hospital pursuant to this section may upon application and notice to the superintendent of the hospital concerned, be granted a temporary leave of absence from the hospital if such leave, in the opinion of the superintendent, will not interfere with

the successful treatment or examination of the applicant for leave.

(3) Upon admission or discharge of a minor to or from a state hospital the superintendent shall immediately notify the parent or guardian. [Amended by 1953 c.127 §2; 1963 c.325 §3; 1967 c.371 §1; 1969 c.273 §1]

426.222 [1953 c.597 §1; 1961 c.385 §1; 1969 c.391 §3; 1969 c.638 §4; repealed by 1975 c.690 §28]

426.223 Retaking persons in custody of or committed to department; assistance of peace officers and others. In retaking custody of a mentally ill person who has been committed to the Department of Human Services under ORS 426.130 and who has, without lawful authority, left the custody of the facility to which the person has been assigned under ORS 426.060, or in the case of an allegedly mentally ill person who is in custody under ORS 426.070, 426.095, 426.228 to 426.235 or 426.237 at a hospital or nonhospital facility and who has, without lawful authority, left the hospital or nonhospital facility, the facility director or designee has all the powers provided by ORS 133.225 and 161.255 and may require the assistance of any peace officer or other person. [1975 c.690 §25; 1993 c.484 §20]

426.224 [1953 c.597 §2; 1961 c.385 §2; 1969 c.391 §4; 1969 c.638 §5; repealed by 1975 c.690 §28]

426.225 Voluntary admission to state hospital of committed person; examination by physician. (1) If any person who has been committed to the Department of Human Services under ORS 426.127 or 426.130 (1)(b)(B) or (C) requests, during this period of commitment, voluntary admission to a state hospital, the superintendent shall cause the person to be examined immediately by a physician. If the physician finds the person to be in need of immediate care or treatment for mental illness, the person shall be voluntarily admitted upon request of the person.

(2) If any person who has been committed to the department under ORS 426.127 or 426.130 (1)(b)(B) or (C) requests, during this period of commitment, voluntary admission to a facility approved by the department, the administrator of the facility shall cause the person to be examined immediately by a physician. If the physician finds the person to be in need of immediate care or treatment for mental illness, and the department grants approval, the person shall be voluntarily admitted upon request of the person. [1989 c.993 §2]

426.226 [1953 c.597 §3; 1969 c.391 §5; 1969 c.638 §6; repealed by 1975 c.690 §28]

(Emergency Care and Treatment)

426.228 Custody; authority of peace officers and other persons; transporting to facility; reports; examination of person. (1) A peace officer may take into custody a person who the officer has probable cause to believe is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness. As directed by the community mental health and developmental disabilities program director, a peace officer shall remove a person taken into custody under this section to the nearest hospital or nonhospital facility approved by the Department of Human Services. The officer shall prepare a written report and deliver it to the treating physician. The report shall state:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the community mental health and developmental disabilities program director and a telephone number where the director may be reached at all times.

(2) A peace officer shall take a person into custody when the community mental health and developmental disabilities program director, pursuant to ORS 426.233, notifies the peace officer that the director has probable cause to believe that the person is imminently dangerous to self or to any other person. As directed by the community mental health and developmental disabilities program director, the peace officer shall remove the person to a hospital or nonhospital facility approved by the department. The community mental health and developmental disabilities program director shall prepare a written report that the peace officer shall deliver to the treating physician. The report shall state:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the community mental health and developmental disabilities program director and a telephone number where the director may be reached at all times.

(3) If more than one hour will be required to transport the person to the hospital or nonhospital facility from the location where the person was taken into custody, the peace officer shall obtain, if possible, a certificate from a physician licensed by the Board of Medical Examiners for the State of Oregon stating that the travel will not be detrimental to the person's physical health and that the person is dangerous to self or to any other person and is in need of immediate care or treatment for mental illness. The physician shall have personally exam-

ined the allegedly mentally ill person within 24 hours prior to signing the certificate.

(4) When a peace officer or other authorized person, acting under this section, delivers a person to a hospital or nonhospital facility, a physician licensed by the Board of Medical Examiners for the State of Oregon shall examine the person immediately. If the physician finds the person to be in need of emergency care or treatment for mental illness, the physician shall proceed under ORS 426.232, otherwise the person shall not be retained in custody. If the person is to be released from custody, the peace officer or the community mental health and developmental disabilities program director shall return the person to the place where the person was taken into custody unless the person declines that service.

(5) A peace officer may transfer a person in custody under this section to the custody of a person authorized by the county governing body under ORS 426.233 (3). The peace officer may meet the authorized person at any location that is in accordance with ORS 426.140 to effect the transfer. When transferring a person in custody to an authorized person, the peace officer shall deliver the report required under subsections (1) and (2) of this section to the authorized person.

(6) A person authorized under ORS 426.233 (3) shall take a person into custody when directed to do so by a peace officer or by a community mental health and developmental disabilities program director under ORS 426.233.

(7) A person authorized under ORS 426.233 (3) shall perform the duties of the peace officer or the community mental health and developmental disabilities program director required by this section and ORS 426.233 if the peace officer or the director has not already done so.

(8) A person authorized under ORS 426.233 (3) may transfer a person in custody under this section to the custody of another person authorized under ORS 426.233 (3) or a peace officer. The authorized person transferring custody may meet another authorized person or a peace officer at any location that is in accordance with ORS 426.140 to effect the transfer. [1993 c.484 §2; 1997 c.531 §2]

Note: 426.228 to 426.238 were added to and made a part of 426.005 to 426.390 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

426.230 [Amended by 1955 c.651 §7; repealed by 1957 c.388 §17]

426.231 Physician hold; when authorized; statement required. (1) A physician licensed by the Board of Medical Examiners for the State of Oregon may hold a person for transportation to a treatment facility for up to 12 hours in a health care facility licensed under ORS chapter 431 and approved by the Department of Human Services if:

(a) The physician believes the person is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness;

(b) The physician is not related to the person by blood or marriage; and

(c) An admitting physician at the receiving facility consents to the transporting.

(2) Before transporting the person, the physician shall prepare a written statement that:

(a) The physician has examined the person within the preceding 12 hours;

(b) An admitting physician at the receiving facility has consented to the transporting of the person for examination and admission if appropriate; and

(c) The physician believes the person is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness.

(3) The written statement required by subsection (2) of this section authorizes a peace officer, a person authorized under ORS 426.233 or the designee of a community mental health and developmental disabilities program director to transport a person to the treatment facility indicated on the statement. [1993 c.484 §3; 1997 c.531 §3]

Note: See note under 426.228.

426.232 Physician emergency admission; notice; limit of hold. (1) When a physician licensed to practice medicine by the Board of Medical Examiners for the State of Oregon believes a person who is brought to a hospital or nonhospital facility by a peace officer under ORS 426.228, a person authorized under ORS 426.233 or a person who is at a hospital or nonhospital facility is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness, the physician may do one of the following:

(a) After consulting with a physician or a qualified mental health professional, as defined by rule of the Department of Human Services, detain the person and cause the person to be admitted or, if the person is already admitted, cause the person to be retained in a hospital where the physician has admitting privileges or is on staff. Neither the physician nor the qualified mental health professional may be related by blood or marriage to the person.

(b) Approve the person for emergency care or treatment at a nonhospital facility approved by the department.

(2) When approving a person for emergency care or treatment at a nonhospital facility under this section, the physician shall notify immediately the community mental health and developmental disabilities program director in the county where the person was taken into custody and maintain the person, if the person is being held at a hospital, for as long as is feasible given the needs of the person for mental or physical health or safety. However, under no circumstances may the person be held for longer than five judicial days. [1993 c.484 §4; 1995 c.201 §3; 1997 c.531 §4]

Note: See note under 426.228.

426.233 Authority of community mental health and developmental disabilities program director and of other persons; costs of transportation. (1)(a) A community mental health and developmental disabilities program director operating under ORS 430.610 to 430.695 or a designee thereof, under authorization of a county governing body, may take one of the actions listed in paragraph (b) of this subsection when the community mental health and developmental disabilities program director or designee has probable cause to believe a person:

(A) Is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness; or

(B)(i) Is a mentally ill person placed on conditional release under ORS 426.125, outpatient commitment under ORS 426.127 or trial visit under ORS 426.273; and

(ii) Is dangerous to self or to any other person or is unable to provide for basic personal needs and is not receiving the care that is necessary for health and safety and is in need of immediate care, custody or treatment for mental illness.

(b) The community mental health and developmental disabilities program director or designee under the circumstances set out in paragraph (a) of this subsection may:

(A) Notify a peace officer to take the person into custody and direct the officer to remove the person to a hospital or nonhospital facility approved by the Department of Human Services;

(B) Authorize involuntary admission of, or, if already admitted, cause to be involuntarily retained in a nonhospital facility approved by the department, a person approved for care or treatment at a nonhospital facility by a physician under ORS 426.232;

(C) Notify a person authorized under subsection (3) of this section to take the person into custody and direct the authorized person to remove the person in custody to a hospital or nonhospital facility approved by the department;

(D) Direct a person authorized under subsection (3) of this section to transport a person in custody from a hospital or a nonhospital facility approved by the department to another hospital or nonhospital facility approved by the department as provided under ORS 426.235; or

(E) Direct a person authorized under subsection (3) of this section to transport a person in custody from a facility approved by the department to another facility approved by the department as provided under ORS 426.060.

(2) A designee under subsection (1) of this section must be recommended by the community mental health and developmental disabilities program director, meet the standards established by rule of the department and be approved by the county governing body before assuming the authority permitted under subsection (1) of this section.

(3) The county governing body may, upon recommendation by the community mental health and developmental disabilities program director, authorize any person to provide custody and secure transportation services for a person in custody under ORS 426.228. In authorizing a person under this subsection, the county governing body shall grant the person the authority to do the following:

(a) Accept custody from a peace officer of a person in custody under ORS 426.228;

(b) Take custody of a person upon notification by the community mental health and developmental disabilities program director under the provisions of this section;

(c) Remove a person in custody to an approved hospital or nonhospital facility as directed by the community mental health and developmental disabilities program director;

(d) Transfer a person in custody to another person authorized under this subsection or a peace officer;

(e) Transfer a person in custody from a hospital or nonhospital facility to another hospital facility or nonhospital facility when directed to do so by the community mental health and developmental disabilities program director; and

(f) Retain a person in custody at the approved hospital or nonhospital facility until a physician makes a determination under ORS 426.232.

(4) A person authorized under subsection (3) of this section must be recommended by the community mental health and developmental disabilities program director, meet the standards established by rule of the department and be approved by the governing

body before assuming the authority granted under this section.

(5) The costs of transporting a person as authorized under ORS 426.060, 426.228 or 426.235 by a person authorized under subsection (3) of this section shall be the responsibility of the county whose peace officer or community mental health and developmental disabilities program director directs the authorized person to take custody of a person and to transport the person to a facility approved by the department, but the county shall not be responsible for costs that exceed the amount provided by the state for that transportation. A person authorized to act under subsection (3) of this section shall charge the cost of emergency medical transportation to, and collect that cost from, the person, third party payers or otherwise legally responsible persons or agencies in the same manner that costs for the transportation of other persons are charged and collected. [1993 c.484 §5; 1997 c.531 §5]

Note: See note under 426.228.

426.234 Duties of professionals at facility where person admitted; notification; duties of court. (1) At the time a person is admitted to or retained in a hospital or nonhospital facility under ORS 426.232 or 426.233, a physician, nurse or qualified mental health professional at the hospital or nonhospital facility shall:

(a) Inform the person of the person's right to representation by or appointment of counsel as described in ORS 426.100;

(b) Give the person the warning under ORS 426.123;

(c) Immediately examine the allegedly mentally ill person; and

(d) Set forth, in writing, the condition of the person and the need for emergency care or treatment.

(2)(a) At the time the person is admitted to or retained in a hospital under ORS 426.232, the physician shall contact the community mental health and developmental disabilities program director of the county in which the person resides, if the county of residence is different from the county in which the hospital is located. The community mental health and developmental disabilities program director may request that the physician notify the circuit court in the county in which the person resides. If the community mental health and developmental disabilities program director does not make the request authorized by this paragraph, the physician shall notify, immediately and in writing, the circuit court in the county in which the person is hospitalized.

(b) At the time the person is admitted to a hospital under ORS 426.232 after being brought to the hospital by a peace officer under ORS 426.228, the physician shall contact the community mental health and developmental disabilities program director of the county in which the person is hospitalized. The community mental health and developmental disabilities program director of the county in which the person is hospitalized may request that the physician notify the circuit court in the county in which the person is hospitalized. If the community mental health and developmental disabilities program director does not make the request authorized by this paragraph, the physician shall notify, immediately and in writing, the circuit court in the county in which the person was taken into custody.

(c) If, at any time prior to the hearing under ORS 426.070 to 426.130, the physician responsible for a person admitted or retained under ORS 426.232 determines that the person is not dangerous to self or others and is not in need of emergency care or treatment for mental illness, the physician may release the person from the detention authorized by ORS 426.232. The physician shall immediately notify the circuit court notified under this subsection and the community mental health and developmental disabilities program director of the person's release from detention.

(3)(a) At the time the person is admitted to or retained in a nonhospital facility under ORS 426.233, the community mental health and developmental disabilities program director in the county where the person was taken into custody shall contact the community mental health and developmental disabilities program director of the county in which the person resides, if the county of residence is different from the county in which the person was taken into custody. The community mental health and developmental disabilities program director of the county in which the person resides may request that the community mental health and developmental disabilities program director of the county in which the person was taken into custody notify the circuit court in the county where the person resides. Otherwise, the community mental health and developmental disabilities program director of the county in which the person was taken into custody shall notify, immediately and in writing, the circuit court in the county in which the person was taken into custody.

(b) If, at any time prior to the hearing under ORS 426.070 to 426.130, a community mental health and developmental disabilities program director, after consultation with a physician, determines that a person admitted or retained under ORS 426.233 is not dangerous to self or others and is not in need

of immediate care, custody or treatment for mental illness, the community mental health and developmental disabilities program director may release the person from detention. The community mental health and developmental disabilities program director shall immediately notify the circuit court originally notified under paragraph (a) of this subsection of the person's release from detention.

(4) When the judge of the circuit court receives notice under subsection (2) or (3) of this section, the judge immediately shall commence proceedings under ORS 426.070 to 426.130. In a county having a population of 100,000 or more, and when feasible in a county with a lesser population, the community mental health and developmental disabilities program director or designee who directs the peace officer or other authorized person to take a person into custody under ORS 426.233 shall not also conduct the investigation as provided for under ORS 426.074. Except when a person is being held under ORS 426.237 (1)(b), a person shall not be held under ORS 426.232 or 426.233 for more than five judicial days without a hearing being held under ORS 426.070 to 426.130.

(5) When the judge of the circuit court receives notice under subsection (2)(c) or (3)(b) of this section that a person has been released, and unless the court receives the recommendation required by ORS 426.070 (4), the judge shall dismiss the case no later than 14 days after the date the person was initially detained. [1993 c.484 §6; 1995 c.201 §1; 1997 c.531 §6; 2001 c.481 §3]

Note: See note under 426.228.

426.235 Transfer between hospital and nonhospital facilities. (1) The community mental health and developmental disabilities program director may transfer a person in custody under ORS 426.232, 426.233 or 426.237 (1)(b) to a hospital or nonhospital facility approved by the Department of Human Services at any time during the period of detention.

(2) A person in custody at a hospital may be transferred from the hospital only with the consent of the treating physician and when the director of a nonhospital facility approved by the department agrees to admit the person.

(3) A person in custody at a nonhospital facility approved by the department may be transferred to a hospital approved by the department only when a physician with admitting privileges agrees to admit the person.

(4) In transporting a person between a hospital and nonhospital facility under this section, the community mental health and developmental disabilities program director has all the powers provided in ORS 133.225 and 161.255 and may compel the assistance of any peace officer or other person.

(5) When a person is transferred under this section, the community mental health and developmental disabilities program director shall notify immediately the court notified under ORS 426.234 (2) or (3) of the fact of the transfer and of the location of the person. [1993 c.484 §7]

Note: See note under 426.228.

426.236 Rules. The Department of Human Services shall adopt rules necessary to carry out the provisions of ORS 426.155 and 426.228 to 426.238. [1993 c.484 §8; 2001 c.481 §4]

Note: See note under 426.228.

426.237 Prehearing detention; duties of community mental health and developmental disabilities program director; certification for treatment; court proceedings. (1) During a prehearing period of detention as provided in ORS 426.070, 426.140, 426.232 or 426.233, the community mental health and developmental disabilities program director shall do one of the following:

(a) Recommend, in an investigation report as provided in ORS 426.074, that the circuit court not proceed further in the matter if the community mental health and developmental disabilities program director does not believe the person is a mentally ill person.

(b) No later than three judicial days after initiation of a prehearing period of detention as provided in ORS 426.070, 426.140, 426.232 or 426.233, certify the detained person for a 14-day period of intensive treatment if:

(A) The community mental health and developmental disabilities program director and a psychiatrist, as defined by rule by the Department of Human Services, have probable cause to believe the person is a mentally ill person;

(B) The community mental health and developmental disabilities program director in the county where the person resides verbally approves the arrangements for payment for the services at the hospital or nonhospital facility; and

(C) The community mental health and developmental disabilities program director locates a hospital or nonhospital facility that:

(i) Is approved by the department and the community mental health and developmental disabilities program director in the county where the person resides; and

(ii) Can, in the opinion of the community mental health and developmental disabilities program director and the psychiatrist, pro-

vide intensive care or treatment for mental illness necessary and sufficient to meet the emergency psychiatric needs of the person.

(c) Recommend, in an investigation report as provided in ORS 426.074, that the circuit court hold a hearing under ORS 426.070 to 426.130 if the community mental health and developmental disabilities program director has probable cause to believe the person is a mentally ill person.

(2)(a) If the circuit court adopts the recommendation of the community mental health and developmental disabilities program director under subsection (1)(a) of this section, the circuit court shall enter an order releasing the person and dismissing the case. Unless the person agrees to voluntary treatment, if the person is being detained in a:

(A) Nonhospital facility, the director shall make discharge plans and insure the discharge of the person.

(B) Hospital, the treating physician shall make discharge plans and discharge the person.

(b) Upon release of the person, the community mental health and developmental disabilities program director shall attempt to notify the person's next of kin if the person consents to the notification.

(3)(a) If the detained person is certified for treatment under subsection (1)(b) of this section, the community mental health and developmental disabilities program director shall:

(A) Deliver immediately a certificate to the court having jurisdiction under ORS 426.060; and

(B) Orally inform the person of the certification and deliver a copy of the certificate to the person.

(b) The certificate required by paragraph (a) of this subsection shall include:

(A) A written statement under oath by the community mental health and developmental disabilities program director and the psychiatrist that they have probable cause to believe the person is a mentally ill person in need of care or treatment for mental illness;

(B) A treatment plan that describes, in general terms, the types of treatment and medication to be provided to the person during the 14-day period of intensive treatment;

(C) A notice of the person's right to an attorney and that an attorney will be appointed by the court or as otherwise obtained under ORS 426.100 (3);

(D) A notice that the person has a right to request and be provided a hearing under ORS 426.070 to 426.130 at any time during the 14-day period; and

(E) The date and time the copy of the certificate was delivered to the person.

(c) Immediately upon receipt of a certificate under paragraph (a) of this subsection, the court shall notify the person's attorney or appoint an attorney for the person if the person cannot afford one. Within 24 hours of the time the certificate is delivered to the court, the person's attorney shall review the certificate with the person. If the person and the person's attorney consent to the certification within one judicial day of the time the certificate is delivered to the circuit court and, except as provided in subsection (4) of this section, the court shall postpone the hearing required by ORS 426.070 to 426.130 for 14 days.

(d) When a person is certified for treatment under subsection (1)(b) of this section and accepts the certification:

(A) Except as otherwise provided in this paragraph, all methods of treatment, including the prescription and administration of drugs, shall be the sole responsibility of the treating physician. However, the person shall not be subject to electro-shock therapy or unduly hazardous treatment and shall receive usual and customary treatment in accordance with medical standards in the community.

(B) Except when the person expressly refuses treatment, the treating physician shall treat the person within the scope of the treatment plan provided the person under paragraph (b) of this subsection. The person's refusal of treatment constitutes sufficient grounds for the community mental health and developmental disabilities program director to request a hearing as provided in subsection (4)(a) of this section.

(C) If the person is in a hospital and the community mental health and developmental disabilities program director locates a nonhospital facility, approved by the department, that, in the opinion of the community mental health and developmental disabilities program director and the treating physician, can provide care or treatment for mental illness necessary and sufficient to meet the emergency psychiatric needs of the person, the treating physician shall discharge the person from the hospital and the community mental health and developmental disabilities program director shall remove the person to the nonhospital facility for the remainder of the 14-day intensive treatment period. If, however, in the opinion of the treating physician, the person's condition requires the person to receive medical care or treatment, the physician shall retain the person in the hospital.

(D) If the person is in a nonhospital facility, the community mental health and developmental disabilities program director shall transfer the person to a hospital approved by the department under the following conditions:

(i) If, in the opinion of a physician, the person's condition requires the person to receive medical care or treatment in a hospital; and

(ii) The physician agrees to admit the person to a hospital, approved by the department, where the physician has admitting privileges.

(E) If the person is transferred as provided in subparagraph (C) or (D) of this paragraph, the community mental health and developmental disabilities program director shall notify the circuit court, in the county where the certificate was filed, of the location of the person. The person may appeal the transfer as provided by rules of the department.

(e) If the person is in a hospital, the treating physician may discharge the person at any time during the 14-day period. The treating physician shall confer with the community mental health and developmental disabilities program director and the person's next of kin, if the person consents to the consultation, prior to discharging the person. Immediately upon discharge of the person, the treating physician shall notify the court in the county in which the certificate was filed initially.

(f) If the person is in a nonhospital facility, the community mental health and developmental disabilities program director may discharge the person at any time during the 14-day period. The community mental health and developmental disabilities program director shall consult with the treating physician and the person's next of kin, if the person consents to the consultation, prior to discharging the person. Immediately upon discharge of the person, the community mental health and developmental disabilities program director shall notify the court in the county in which the certificate was filed initially.

(g) The person may agree to voluntary treatment at any time during the 14-day period. When a person agrees to voluntary treatment under this paragraph, the community mental health and developmental disabilities program director immediately shall notify the court in the county in which the certificate was filed initially.

(h) A person consenting to 14 days of treatment under subsection (3)(c) of this section shall not be held longer than 14 days from the time of consenting without a hearing as provided in ORS 426.070 to 426.130.

(i) When the court receives notification under paragraph (e), (f) or (g) of this subsection, the court shall dismiss the case.

(4) The judge of the circuit court shall immediately commence proceedings under ORS 426.070 to 426.130 when:

(a) The person consenting to 14 days of treatment or the community mental health and developmental disabilities program director requests a hearing. The hearing shall be held without unreasonable delay. In no case shall the person be held in a hospital or nonhospital facility longer than five judicial days after the request for a hearing is made without a hearing being held under ORS 426.070 to 426.130.

(b) The community mental health and developmental disabilities program director acts under subsection (1)(c) of this section. In no case shall the person be held longer than five judicial days without a hearing under this subsection. [1993 c.484 §9]

Note: See note under 426.228.

426.238 Classifying facilities. The Department of Human Services may assign classifications, as defined by rule of the department, to facilities that provide care and treatment for persons committed to the department under ORS 426.130 or provide emergency care or treatment for persons pursuant to ORS 426.070, 426.228 to 426.235 or 426.237. The department may authorize a facility to retake custody of a person who unlawfully leaves a facility as provided in ORS 426.223. [1993 c.484 §10]

Note: See note under 426.228.

426.240 [Amended by 1959 c.652 §22; 1975 c.690 §16; repealed by 1977 c.764 §4 (426.241 enacted in lieu of 426.240)]

(Costs)

426.241 Payment of care, custody and treatment costs; denial of payment; rules. (1) The cost of emergency psychiatric care, custody and treatment related to or resulting from such psychiatric condition, provided by a hospital or other facility approved by the Department of Human Services and the community mental health and developmental disabilities program director of the county in which the facility is located, except a state mental hospital, for an allegedly mentally ill person admitted or detained under ORS 426.070, 426.140, 426.228, 426.232 or 426.233, or for a mentally ill person admitted or detained under ORS 426.150, 426.223, 426.273, 426.275 or 426.292, shall be paid by the county of which the person is a resident from state funds provided it for this purpose. The county is responsible for the cost when

state funds available therefor are exhausted. The hospital or other facility shall charge to and collect from the person, third party payers or other persons or agencies otherwise legally responsible therefor, the costs of the emergency care, custody and treatment, as it would for any other patient, and any funds received shall be applied as an offset to the cost of the services provided under this section.

(2) If any person is admitted to or detained in a state mental hospital under ORS 426.070, 426.140, 426.180 to 426.210, 426.228, 426.232 or 426.233 for emergency care, custody or treatment, the department shall charge to and collect from the person, third party payers or other persons or agencies otherwise legally responsible therefor, the costs as it would for other patients of the state mental hospitals under the provisions of ORS 179.610 to 179.770.

(3) If any person is adjudged mentally ill under the provisions of ORS 426.130, and the person receives care and treatment in a state mental hospital, the person, third party payers or other persons or agencies otherwise legally responsible therefor, shall be required to pay for the costs of the hospitalization at the state hospital, as provided by ORS 179.610 to 179.770, if financially able to do so.

(4) For purposes of this section and ORS 426.310 "resident" means resident of the county in which the person maintains a current mailing address or, if the person does not maintain a current mailing address within the state, the county in which the person is found, or the county in which a court committed mentally ill person has been conditionally released.

(5)(a) The department may deny payment for part or all of the emergency psychiatric services provided by a hospital or nonhospital facility under ORS 426.232, 426.233 or 426.237 when the department finds, upon review, that the allegedly mentally ill person's condition did not meet the admission criteria in ORS 426.232 (1), 426.233 (1) or 426.237 (1)(b)(A). The payer responsible under this section shall make a request for denial of payment for emergency psychiatric services provided under ORS 426.232, 426.233 or 426.237 in writing to the department.

(b) The department may require the following to provide the department with any information the department determines necessary to review a request for denial of payment made under this subsection and to make a finding, or to conduct review of emergency psychiatric services for the purpose of planning or defining standards in department rule:

(A) A hospital or nonhospital facility approved under ORS 426.228 to 426.235 or 426.237.

(B) A physician or a person providing emergency psychiatric services under ORS 426.228 to 426.235 or 426.237.

(c) The department shall adopt rules necessary to carry out the purposes of this subsection. [1977 c.764 §5 (enacted in lieu of 426.240); 1979 c.392 §1; 1981 c.750 §16; 1987 c.527 §1; 1993 c.484 §21]

426.250 Payment of costs related to commitment proceedings. The following is a nonexclusive list of responsibilities for payment of various costs related to commitment proceedings under this chapter and ORS 430.397 to 430.401 as described:

(1) Any physician or qualified person recommended by the Department of Human Services who is employed under ORS 426.110 to make an examination as to the mental condition of a person alleged to be mentally ill shall be allowed a fee as the court in its discretion determines reasonable for the examination.

(2) Witnesses subpoenaed to give testimony shall receive the same fees as are paid in criminal cases, and are subject to compulsory attendance in the same manner as provided in ORS 136.567 to 136.603. The attendance of out-of-state witnesses may be secured in the same manner as provided in ORS 136.623 to 136.637. The party who subpoenas the witness or requests the court to subpoena the witness is responsible for payment of the cost of the subpoena and payment for the attendance of the witness at a hearing. When the witness has been subpoenaed on behalf of an allegedly mentally ill person who is represented by court-appointed counsel, the fees and costs allowed for that witness shall be paid pursuant to ORS 135.055. If the costs of witnesses subpoenaed by the allegedly mentally ill person are paid as provided under this subsection, the procedure for subpoenaing witnesses shall comply with ORS 136.570.

(3) If a person with a right to a counsel under ORS 426.100 is unable to afford counsel, the court shall determine and allow, as provided in ORS 135.055, the reasonable expenses of the person and compensation for legal counsel. The expenses and compensation so allowed shall be paid by the state from funds available for the purpose.

(4) The department shall pay the costs of expenses incurred under ORS 426.100 by the Attorney General's office. Any costs for district attorneys or other counsel appointed to assume responsibility for presenting the state's case shall be paid by the county where the commitment hearing is held, subject to reimbursement under ORS 426.310.

(5) All costs incurred in connection with a proceeding under ORS 426.200, including the costs of transportation, commitment and delivery of the person, shall be paid by the county of which the person is a resident; or, if the person is not a resident of this state, then by the county from which the emergency admission was made.

(6) All costs incurred in connection with a proceeding under ORS 426.180 for the commitment of a person from a reservation for land-based tribes of Native Americans, including the cost of transportation, commitment and delivery of the person, shall be paid by the ruling body of the reservation of which the person is a resident. [Amended by 1965 c.420 §2; 1975 c.690 §17; 1977 c.764 §6; 1987 c.606 §9; 1987 c.903 §§26,26a]

Note: The amendments to 426.250 by section 59, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.250. The following is a nonexclusive list of responsibilities for payment of various costs related to commitment proceedings under this chapter and ORS 430.397 to 430.401 as described:

(1) Any physician or qualified person recommended by the Department of Human Services who is employed under ORS 426.110 to make an examination as to the mental condition of a person alleged to be mentally ill shall be allowed a fee as the court in its discretion determines reasonable for the examination.

(2) Witnesses subpoenaed to give testimony shall receive the same fees as are paid in criminal cases, and are subject to compulsory attendance in the same manner as provided in ORS 136.567 to 136.603. The attendance of out-of-state witnesses may be secured in the same manner as provided in ORS 136.623 to 136.637. The party who subpoenas the witness or requests the court to subpoena the witness is responsible for payment of the cost of the subpoena and payment for the attendance of the witness at a hearing. When the witness has been subpoenaed on behalf of an allegedly mentally ill person who is represented by appointed counsel, the fees and costs allowed for that witness shall be paid pursuant to ORS 135.055. If the costs of witnesses subpoenaed by the allegedly mentally ill person are paid as provided under this subsection, the procedure for subpoenaing witnesses shall comply with ORS 136.570.

(3) If a person with a right to a counsel under ORS 426.100 is determined to be financially eligible for appointed counsel at state expense, the public defense services executive director shall determine and pay, as provided in ORS 135.055, the reasonable expenses related to the representation of the person and compensation for legal counsel. The expenses and compensation so allowed shall be paid by the public defense services executive director from funds available for the purpose.

(4) The department shall pay the costs of expenses incurred under ORS 426.100 by the Attorney General's office. Any costs for district attorneys or other counsel appointed to assume responsibility for presenting the state's case shall be paid by the county where the commitment hearing is held, subject to reimbursement under ORS 426.310.

(5) All costs incurred in connection with a proceeding under ORS 426.200, including the costs of transportation, commitment and delivery of the person, shall be paid by the county of which the person is a resident; or, if the person is not a resident of this state, then by the county from which the emergency admission was made.

(6) All costs incurred in connection with a proceeding under ORS 426.180 for the commitment of a person from a reservation for land-based tribes of Native Americans, including the cost of transportation, commitment and delivery of the person, shall be paid by the ruling body of the reservation of which the person is a resident.

426.255 County to pay costs. Costs of hearings conducted pursuant to ORS 426.307, and the fees for physicians and other qualified persons shall be charged to the county of the person's residence in the same manner provided by ORS 426.310, whether the hearing is held in the county of residence or county of the treating facility. [1973 c.838 §19; 1987 c.803 §23; 1987 c.903 §27]

426.260 [Amended by 1955 c.651 §8; repealed by 1957 c.160 §6]

426.270 [Amended by 1955 c.651 §9; repealed by 1957 c.160 §6]

(Trial Visits; Conditional Release; Outpatient Commitment; Early Release)

426.273 Trial visits. (1) During a period of commitment of a patient under ORS 426.130, the Department of Human Services may grant a trial visit to the patient for a period of time and under any conditions the department shall establish. The department shall only grant a trial visit under this section if the trial visit is agreed to by the community mental health and developmental disabilities program director, or the designee of the director, for the county in which the person would reside.

(2) When in the opinion of the department, the committed person can be appropriately served by outpatient care during the period of commitment, the outpatient care may be required as a condition for trial visit for a period which, when added to the inpatient treatment period, shall not exceed the period of commitment. If outpatient care is required as a condition for a trial visit, the conditions shall include a designation of a facility, service or other provider to provide care or treatment.

(3) A copy of the conditions for trial visit shall be given to all of the persons listed in ORS 426.278.

(4) Any trial visit granted under this section is subject to the provisions under ORS 426.275.

(5) The director of the community mental health and developmental disabilities program, or designee, of the county in which a person who is on trial visit lives while on trial visit may modify the conditions for continued trial visit when such modification is in the best interest of the person. The director shall send notification of such changes and the reasons for the changes to all those

who received a copy of the original conditions under ORS 426.278. [1985 c.242 §2 (enacted in lieu of 426.290); 1987 c.903 §28]

426.275 Effect of failure to adhere to condition of placement. The following are applicable to placements of mentally ill persons that are made as conditional release under ORS 426.125, outpatient commitments under ORS 426.127 or trial visits under ORS 426.273 as described:

(1) If the person responsible under this subsection determines that the mentally ill person is failing to adhere to the terms and conditions of the placement, the responsible person shall notify the court having jurisdiction that the mentally ill person is not adhering to the terms and conditions of the placement. If the placement is an outpatient commitment under ORS 426.127 or a trial visit under ORS 426.273, the notifications shall include a copy of the conditions for the placement. The person responsible for notifying the court under this subsection is as follows:

(a) For conditional releases under ORS 426.125, the guardian, relative or friend in whose care the mentally ill person is conditionally released.

(b) For outpatient commitments under ORS 426.127, the community mental health and developmental disabilities program director, or designee of the director, of the county in which the person on outpatient commitment lives.

(c) For trial visits under ORS 426.273, the community mental health and developmental disabilities program director, or designee of the director, of the county in which the person on trial visit is to receive outpatient treatment.

(2) On its own motion, the court with jurisdiction of a mentally ill person on such placement may cause the person to be brought before it for a hearing to determine whether the person is or is not adhering to the terms and conditions of the placement. The person shall have the same rights with respect to notice, detention stay, hearing and counsel as for a hearing held under ORS 426.095. The court shall hold the hearing within five judicial days of the date the mentally ill person receives notice under this section. The court may allow postponement and detention during postponement as provided under ORS 426.095.

(3) Pursuant to the determination of the court upon hearing under this section, a person on placement shall either continue the placement on the same or modified conditions or shall be returned to the Department of Human Services for involuntary care and treatment on an inpatient basis subject to discharge at the end of the commitment period or as otherwise provided under this chapter and ORS 430.397 to 430.401.

(4) If the person on placement is living in a county other than the county of the court that established the current period of commitment under ORS 426.130 during which the trial visit, conditional release or outpatient commitment takes place, the court establishing the current period of commitment shall transfer jurisdiction to the appropriate court of the county in which the person is living while on the placement and the court receiving the transfer shall accept jurisdiction.

(5) The court may proceed as provided in ORS 426.307 or this section when the court:

(a) Receives notice under ORS 426.070 or 426.228 to 426.235; and

(b) Determines that the person is a mentally ill person on conditional release under ORS 426.125, outpatient commitment under ORS 426.127 or trial visit under ORS 426.273. [1985 c.242 §3 (enacted in lieu of 426.290); 1987 c.903 §29; 1993 c.484 §22]

426.278 Distribution of copies of conditions for outpatient commitment or trial visit. The following persons shall be given a copy of the conditions of a placement of a mentally ill person that is made as an outpatient commitment under ORS 426.127 or as a trial visit under ORS 426.273:

(1) The committed person;

(2) The community mental health and developmental disabilities program director, or designee of the director, of the county in which the committed person is to receive outpatient treatment;

(3) The director of any facility, service or other provider designated to provide care or treatment;

(4) The court of current commitment; and

(5) The appropriate court of the county in which the committed person lives during the commitment period if the person is living in a different county than the county of the court that made the current commitment. [1987 c.903 §30]

426.280 Limitations on liability. The following limitations on liability and circumstances are applicable to situations within this chapter and ORS 430.397 to 430.401:

(1) None of the following shall in any way be held criminally or civilly liable for the making of the notification under ORS 426.070, provided the person acts in good faith, on probable cause and without malice:

(a) The community mental health and developmental disabilities program director or designee of the director.

(b) The two petitioning persons.

(c) The county health officer.

(d) Any magistrate.

(e) Any peace officer or probation officer.

(f) Any physician attending the allegedly mentally ill person.

(g) The physician attached to a hospital or institution wherein the allegedly mentally ill person is a patient.

(2) The person conducting the investigation under ORS 426.070 and 426.074 shall not be held criminally or civilly liable for conducting the investigation, provided the investigator acts in good faith, on probable cause and without malice.

(3) The person representing the state's interest under ORS 426.100 shall not be held criminally or civilly liable for performing responsibilities under ORS 426.100 as long as the person acts in good faith and without malice.

(4) No person appointed under ORS 426.110 to conduct an examination under ORS 426.120 shall be held criminally or civilly liable for actions pursuant to ORS 426.120 if the examiner acts in good faith and without malice.

(5) No physician, hospital or judge shall be held criminally or civilly liable for actions pursuant to ORS 426.228, 426.231, 426.232, 426.234 or 426.235 if the physician, hospital or judge acts in good faith, on probable cause and without malice.

(6) No peace officer, person authorized under ORS 426.233, community mental health director or designee, hospital or other facility, physician or judge shall in any way be held criminally or civilly liable for actions pursuant to ORS 426.228 to 426.235 if the individual or facility acts in good faith, on probable cause and without malice.

(7) Any guardian, relative or friend of a mentally ill person who assumes responsibility for the mentally ill person under a conditional release under ORS 426.125 shall not be liable for any damages that are sustained by any person on account of the misconduct of the mentally ill person while on conditional release if the guardian, relative or friend acts in good faith and without malice.

(8) The persons designated in this subsection shall not be liable for damages that are sustained by any person or property on account of the misconduct of a mentally ill person while the mentally ill person is on outpatient commitment under ORS 426.127 if the designated person acts without willful and wanton neglect of duty. This subsection is applicable to all of the following:

(a) The community mental health and developmental disabilities program director and the designee of the director for the county in which the committed person resides.

(b) The superintendent or director of any staff of any facility where the mentally ill person receives treatment during the outpatient commitment.

(c) The Director of Human Services.

(d) The physician and the facility granting an outpatient commitment to a patient.

(9) For trial visits granted under ORS 426.273 and 426.275:

(a) None of the following shall be liable for a patient's expenses while on trial visit:

(A) The physician and the facility granting a trial visit to a patient;

(B) The superintendent or director of the facility granting a trial visit;

(C) The Director of Human Services; and

(D) The chief medical officer of the facility.

(b) The following persons shall not be liable for damages that are sustained by any person on account of the misconduct of such patient while on trial visit if the person acts without willful and wanton neglect of duty:

(A) The community mental health and developmental disabilities program director for the county in which the person resides;

(B) The superintendent, director or chief medical officer of any facility granting a trial visit to a patient;

(C) The physician responsible for the patient's trial visit;

(D) The Director of Human Services; or

(E) The employees and agents of persons listed in this paragraph. [Amended by 1961 c.228 §1; 1961 c.706 §26; 1969 c.597 §91; 1973 c.838 §26; 1985 c.242 §5; 1987 c.903 §31; 1993 c.484 §23; 1997 c.531 §7]

426.290 [Amended by 1959 c.513 §1; 1961 c.228 §2; 1969 c.391 §6; 1973 c.838 §27; 1975 c.690 §18; repealed by 1985 c.242 §1 (426.273, 426.275 and 426.292 enacted in lieu of 426.290)]

426.292 Release prior to expiration of term of commitment. Nothing in this chapter and ORS 430.397 to 430.401 prohibits the Department of Human Services from releasing a person from a hospital or other facility in which the person is being treated prior to the expiration of the period of commitment under ORS 426.130 when, in the opinion of the director of the facility or treating physician, the person is no longer mentally ill. [1985 c.242 §4 (enacted in lieu of 426.290)]

(Competency and Discharge)

426.295 Judicial determination of competency; restoration of competency. (1) No person admitted to a state hospital for the treatment of mental illness shall be con-

sidered by virtue of the admission to be incompetent.

(2) Upon petition of a person committed to a state hospital, or the guardian, relative or creditor of the person or other interested person, the court of competent jurisdiction in the county in which the state hospital is located or, if the petitioner requests a hearing in the county where the commitment originated, then the court in such county shall hold a hearing to determine whether or not the person in the state hospital is competent. A guardian who is not the petitioner shall be notified of the hearing at least three days before the date set for hearing. After the hearing the court shall enter an order pursuant to its finding and serve a copy of the order on the petitioner and forward a copy of the order to the committing court.

(3) When a person committed to a state hospital has been declared incompetent pursuant to subsection (2) of this section and is discharged from the hospital, the superintendent of the hospital shall advise the court which entered the order of incompetency whether or not, in the opinion of the chief medical officer of the hospital on the basis of medical evidence, the person is competent. The superintendent shall make a reasonable effort to notify the discharged person of the advice to the court. If the court is advised that the person is competent, the court shall enter an order to that effect. If the court is advised that the person is not competent, upon petition of the person, the guardian, relative or creditor of the person or other interested person, the court shall hold a hearing to determine whether or not the discharged person is competent. The court shall serve a copy of any order entered pursuant to this subsection on the person and forward a copy of such order to the committing court. [1965 c.628 §2; 1967 c.460 §1; 1969 c.391 §7]

426.297 Payment of expenses for proceeding under ORS 426.295. (1) The expenses of a proceeding under ORS 426.295 (2) shall be paid by the person, unless it appears from the affidavit of the person or other evidence that the person is unable to pay the expenses. If the person is unable to pay, the expenses of the proceedings shall be paid by the county of which the mentally ill person was a resident at the time of admission. If the county of residence cannot be established, the county from which the person was admitted shall pay the expenses.

(2) The expenses of the proceeding under ORS 426.295 (3) shall be paid by the petitioner.

(3) Any physician employed by the court to make an examination as to the mental condition of a person subject to a competency proceeding under ORS 426.295 or 426.380 to 426.390 shall be allowed a reasonable professional fee by order of the court. Witnesses summoned and giving testimony shall receive the same fees as are paid in ORS 44.415 (2). [1967 c.460 §2; 1989 c.980 §14]

426.300 Discharge of patients; application for public assistance. (1) The Department of Human Services shall, by filing a written certificate with the last committing court and the court of residence, discharge any patient from court commitment, except one held upon an order of a court or judge having criminal jurisdiction in an action or proceeding arising out of criminal offense when in its opinion the individual is no longer a mentally ill person or when in its opinion the transfer of the individual to a voluntary status is in the best interest of the treatment of the patient.

(2) The department may sign applications for public assistance on behalf of those patients who may be eligible for public assistance. [Amended by 1963 c.325 §4; 1967 c.549 §8; 1973 c.838 §22; 1997 c.249 §137]

426.301 Release of committed patient; certification of continued mental illness; service of certificate; content; period of further commitment; effect of failure to protest further commitment. (1) At the end of the 180-day period of commitment, any person whose status has not been changed to voluntary shall be released unless the Department of Human Services certifies to the court in the county where the treating facility is located that the person is still mentally ill and in need of further treatment. The department, pursuant to its rules, may delegate to the director of the treating facility the responsibility for making the certification. The director of the treating facility shall consult with the community mental health and developmental disabilities program director of the county of residence prior to making the certification. If the certification is made, the person will not be released, but the director of the treating facility shall immediately issue a copy of the certification to the person and to the community mental health and developmental disabilities program director of the county of residence.

(2) The certification shall be served upon the person by the director of the facility wherein the person is confined or the designee of the director. The director of the facility shall inform the court in writing that service has been made and the date thereof.

(3) The certification shall advise the person of all the following:

(a) That the department or facility has requested that commitment be continued for an additional period of time.

(b) That the person may consult with legal counsel and that legal counsel will be provided for the person without cost if the person is unable to afford legal counsel.

(c) That the person may protest this further commitment within 14 days, and if the person does not commitment will be continued for an indefinite period of time up to 180 days.

(d) That if the person does protest a further period of commitment, the person is entitled to a hearing before the court on whether commitment should be continued.

(e) That the person may protest either orally or in writing by signing the form accompanying the certification; that the person is entitled to have a physician or other qualified person as recommended by the department, other than a member of the staff at the facility where the person is confined, examine the person and report to the court the results of the examination.

(f) That the person may subpoena witnesses and offer evidence on behalf of the person at the hearing.

(g) That if the person is without funds to retain legal counsel or an examining physician or qualified person as recommended by the department, the court will appoint legal counsel, a physician or other qualified person at no cost to the person.

(4) Nothing in subsection (3) of this section requires the giving of the warning under ORS 426.123.

(5) The person serving the certification shall read and deliver the certification to the person and ask whether the person protests a further period of commitment. The person may protest further commitment either orally or by signing a simple protest form to be given to the person with the certification. If the person does not protest a further period of commitment within 14 days of service of the certification, the department or facility shall so notify the court and the court shall, without further hearing, order the commitment of the person for an additional indefinite period of time up to 180 days. [1973 c.838 §15; 1975 c.690 §19; 1987 c.903 §32]

Note: The amendments to 426.301 by section 60, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.301. (1) At the end of the 180-day period of commitment, any person whose status has not been changed to voluntary shall be released unless the Department of Human Services certifies to the court in the county where the treating facility is located that the person is still mentally ill and in need of further treatment. The department, pursuant to its rules, may delegate to the director of the treating facility the responsibility for making the certification. The director of the treating facility shall consult with the community mental health and developmental disabilities program director of the county of residence prior to making the certification. If the certification is made, the person will not be released, but the director of the treating facility shall immediately issue a copy of the certification to the person and to the community mental health and developmental disabilities program director of the county of residence.

(2) The certification shall be served upon the person by the director of the facility wherein the person is confined or the designee of the director. The director of the facility shall inform the court in writing that service has been made and the date thereof.

(3) The certification shall advise the person of all the following:

(a) That the department or facility has requested that commitment be continued for an additional period of time.

(b) That the person may consult with legal counsel and that legal counsel will be provided for the person without cost if the person is unable to afford legal counsel.

(c) That the person may protest this further commitment within 14 days, and if the person does not commitment will be continued for an indefinite period of time up to 180 days.

(d) That if the person does protest a further period of commitment, the person is entitled to a hearing before the court on whether commitment should be continued.

(e) That the person may protest either orally or in writing by signing the form accompanying the certification; that the person is entitled to have a physician or other qualified person as recommended by the department, other than a member of the staff at the facility where the person is confined, examine the person and report to the court the results of the examination.

(f) That the person may subpoena witnesses and offer evidence on behalf of the person at the hearing.

(g) That if the person is without funds to retain legal counsel or an examining physician or qualified person as recommended by the department, the court will appoint legal counsel, a physician or other qualified person.

(4) Nothing in subsection (3) of this section requires the giving of the warning under ORS 426.123.

(5) The person serving the certification shall read and deliver the certification to the person and ask whether the person protests a further period of commitment. The person may protest further commitment either orally or by signing a simple protest form to be given to the person with the certification. If the person does not protest a further period of commitment within 14 days of service of the certification, the department or facility shall so notify the court and the court shall, without further hearing, order the commitment of the person for an additional indefinite period of time up to 180 days.

426.303 Effect of protest of further commitment; advice of court. When the person protests a further period of commitment the Department of Human Services or facility designated in accordance with ORS 426.301 shall immediately notify the court and the court shall have the person brought before it and shall again advise the person that the department or facility has requested that commitment be continued for an additional period of time and that if the person does not protest this commitment the commitment will be continued for an indefinite period of time up to 180 days. The person

shall also be informed of the rights set forth in ORS 426.301. [1973 c.838 §16; 1975 c.690 §20]

426.305 [1955 c.522 §4; 1963 c.325 §5; repealed by 1965 c.628 §3]

426.307 Court hearing; continuance; attorney; examination; determination of mental illness; order of further commitment; period of commitment. If the person requests a hearing under ORS 426.301 or if the court proceeds under ORS 426.275 (5), the following provisions apply as described:

(1) The hearing shall be conducted as promptly as possible and at a time and place as the court may direct.

(2) If the person requests a continuance in order to prepare for the hearing or to obtain legal counsel to represent the person, the court may grant postponement and detention during postponement as provided under ORS 426.095.

(3) The person has the right to representation by or appointment of counsel as provided under ORS 426.100 subject to ORS 135.055, 151.430 to 151.480 and applicable contracts entered into under ORS 151.460.

(4) If the person requests an examination by a physician or other qualified person as recommended by the Department of Human Services and is without funds to retain a physician or other qualified person for purposes of the examination, the court shall appoint a physician or other qualified person, other than a member of the staff from the facility where the person is confined, to examine the person at no expense to the person and to report to the court the results of the examination.

(5) The provisions of ORS 40.230, 40.235, 40.240 and 40.250 do not apply to the use of medical records from the current period of commitment or to testimony related to such records or period of commitment in connection with hearings under this section. The court may consider as evidence such reports and testimony.

(6) The court shall then conduct a hearing and after hearing the evidence and reviewing the recommendations of the treating and examining physicians or other qualified persons, the court shall determine whether the person is still a mentally ill person and in need of further treatment. If in the opinion of the court the individual is still a mentally ill person by clear and convincing evidence and in need of further treatment, the court may order commitment to the department for an additional indefinite period of time up to 180 days.

(7) At the end of the 180-day period, the person shall be released unless the department or facility again certifies to the committing court that the person is still a mentally ill person and in need of further treatment, in which event the procedures set forth in ORS 426.301 to 426.307 shall be followed. [1973 c.838 §17; 1975 c.690 §21; 1979 c.408 §5; 1987 c.803 §24; 1987 c.903 §§33,33a; 1989 c.171 §53; 1993 c.484 §24; 1997 c.649 §4]

Note: The amendments to 426.307 by section 61, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.307. If the person requests a hearing under ORS 426.301 or if the court proceeds under ORS 426.275 (5), the following provisions apply as described:

(1) The hearing shall be conducted as promptly as possible and at a time and place as the court may direct.

(2) If the person requests a continuance in order to prepare for the hearing or to obtain legal counsel to represent the person, the court may grant postponement and detention during postponement as provided under ORS 426.095.

(3) The person has the right to representation by or appointment of counsel as provided under ORS 426.100 subject to ORS 135.055, 151.216 and 151.219.

(4) If the person requests an examination by a physician or other qualified person as recommended by the Department of Human Services and is without funds to retain a physician or other qualified person for purposes of the examination, the court shall appoint a physician or other qualified person, other than a member of the staff from the facility where the person is confined, to examine the person at no expense to the person and to report to the court the results of the examination.

(5) The provisions of ORS 40.230, 40.235, 40.240 and 40.250 do not apply to the use of medical records from the current period of commitment or to testimony related to such records or period of commitment in connection with hearings under this section. The court may consider as evidence such reports and testimony.

(6) The court shall then conduct a hearing and after hearing the evidence and reviewing the recommendations of the treating and examining physicians or other qualified persons, the court shall determine whether the person is still a mentally ill person and in need of further treatment. If in the opinion of the court the individual is still a mentally ill person by clear and convincing evidence and in need of further treatment, the court may order commitment to the department for an additional indefinite period of time up to 180 days.

(7) At the end of the 180-day period, the person shall be released unless the department or facility again certifies to the committing court that the person is still a mentally ill person and in need of further treatment, in which event the procedures set forth in ORS 426.301 to 426.307 shall be followed.

426.309 Effect of ORS 426.217 and 426.301 to 426.307 on other discharge procedure. ORS 426.217 and 426.301 to 426.307 do not restrict or limit the discharge procedures set forth in ORS 426.300. [1973 c.838 §20]

(Miscellaneous)

426.310 Reimbursement of county in case of nonresident patients. (1) If the mentally ill person is a resident of some other county in this state, the county making the commitment shall be reimbursed by the county of which the person is a resident. All

reasonable and actual expenses incurred and paid by the county by reason of the care, custody, treatment, investigation examination and commitment hearing shall, upon presentation of a copy of the order of the judge making the examination and commitment, together with a properly itemized and certified claim covering the expense, be promptly paid to the county by the county of which the person was a resident. The expenses reimbursed under this subsection shall include any expenses incurred to pay for representation of the state's interest under ORS 426.100 and 426.250.

(2) If an allegedly mentally ill person is a resident of some other county in this state, a county attempting a commitment shall be reimbursed by the county of which the person is a resident, as defined in ORS 426.241, for all actual, reasonable expenses incurred and paid by the county attempting commitment by reason of the care, custody, treatment, investigation examination and commitment hearing. The expenses reimbursed under this subsection shall include any expenses incurred to pay for representation of the state's interest under ORS 426.100 and 426.250. [Amended by 1975 c.690 §22; 1977 c.764 §7; 1979 c.392 §2; 1987 c.903 §34]

426.320 Payment of certain expenses by the state. When a mentally ill person is assigned to or transferred to a state mental hospital, all actual and necessary expenses incurred by the agent or attendant from the state hospital and the assistants of the agent or attendant, together with those of the person for transportation to the hospital, shall be paid by the state in the manner provided in ORS 426.330. [Amended by 1975 c.690 §23]

426.330 Presentation and payment of claims. The special funds authorized for the use of the superintendents of the Oregon State Hospital, the Eastern Oregon Psychiatric Center and the Eastern Oregon Training Center to better enable them promptly to meet the advances and expenses necessary in the matter of transferring patients to the state hospitals are continued in existence. The superintendents shall present their claims monthly with proper vouchers attached, showing the expenditures from the special funds during the preceding month, which claims, when approved by the Department of Human Services, shall be paid by warrant upon the State Treasurer against the fund appropriated to cover the cost of transporting the mentally diseased. [Amended by 1975 c.614 §14; 1985 c.565 §67]

426.340 [Repealed by 1975 c.690 §28]

426.350 [Amended by 1961 c.152 §1; repealed by 1971 c.64 §12]

426.360 [1961 c.513 §§1,2,3; 1969 c.597 §92; 1971 c.655 §246; 1977 c.253 §40; repealed by 2001 c.900 §261]

426.370 Withholding information obtained in certain commitment or admission investigations. A community mental health and developmental disabilities program director or designee may withhold information obtained during an investigation under ORS 426.070, 426.228, 426.232, 426.233 or 426.234 if the community mental health and developmental disabilities program director determines:

(1) That information was not included in its investigation report or otherwise used in a material way to support a determination by the community mental health and developmental disabilities program director that there was probable cause to believe a person was a mentally ill person; and

(2) Release of the information would constitute a clear and immediate danger to any person. [1989 c.993 §6; 1993 c.484 §25]

Note: 426.370 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 426 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

426.375 [1967 c.460 §5; repealed by 1973 c.838 §29]

(Rights of Committed Persons)

426.380 Availability of writ of habeas corpus. Any individual committed pursuant to ORS 426.005 to 426.223 and 426.241 to 426.380 shall be entitled to the writ of habeas corpus upon proper petition by the individual or a friend to any court generally empowered to issue the writ of habeas corpus in the county in which the state hospital in which the person is detained is located. [1967 c.460 §6]

426.385 Rights of committed persons; notice of limitation of rights; consent for certain procedures; psychosurgery prohibited; mechanical restraints. (1) Every mentally ill person committed to the Department of Human Services shall have the right to:

(a) Communicate freely in person and by reasonable access to telephones;

(b) Send and receive sealed mail, except that this right may be limited for security reasons in state institutions as described in ORS 426.010;

(c) Wear the clothing of the person;

(d) Keep personal possessions, including toilet articles;

(e) Religious freedom;

(f) A private storage area with free access thereto;

(g) Be furnished with a reasonable supply of writing materials and stamps;

(h) A written treatment plan, kept current with the progress of the person;

(i) Be represented by counsel whenever the substantial rights of the person may be affected;

(j) Petition for a writ of habeas corpus;

(k) Not be required to perform routine labor tasks of the facility except those essential for treatment;

(L) Be given reasonable compensation for all work performed other than personal housekeeping duties;

(m) Such other rights as may be specified by rule; and

(n) Exercise all civil rights in the same manner and with the same effect as one not admitted to the facility, including, but not limited to, the right to dispose of real property, execute instruments, make purchases, enter contractual relationships, and vote, unless the person has been adjudicated incompetent and has not been restored to legal capacity. Disposal of personal property in possession of the person in a state institution described in ORS 426.010 is subject to limitation for security reasons.

(2)(a) A person must be immediately informed, verbally and in writing, of any limitation:

(A) Of the right to send or receive sealed mail under subsection (1)(b) of this section; or

(B) Regarding the disposal of personal property under subsection (1)(n) of this section.

(b) Any limitation under this subsection and the reasons for the limitation must be stated in the person's written treatment plan.

(c) The person has the right to challenge any limitation under this subsection pursuant to rules adopted by the department. The person must be informed, verbally and in writing, of this right.

(3) Mentally ill persons committed to the department shall have the right to be free from potentially unusual or hazardous treatment procedures, including convulsive therapy, unless they have given their express and informed consent or authorized the treatment pursuant to ORS 127.700 to 127.737. This right may be denied to such persons for good cause as defined in administrative rule only by the director of the facility in which the person is confined, but only after consultation with and approval of an independent examining physician. Any denial shall be entered into the patient's treatment record and shall include the reasons for the denial. No patient shall be subjected to psychosurgery, as defined in ORS 677.190 (22)(b).

(4) Mechanical restraints shall not be applied to a person admitted to a facility unless it is determined by the chief medical officer of the facility or designee to be required by the medical needs of the person. Every use of a mechanical restraint and the reasons therefor shall be made a part of the clinical record of the person over the signature of the chief medical officer of the facility or designee.

(5) Nothing in this section prevents the department from acting to exclude contraband from its facilities and to prevent possession or use of contraband in its facilities.

(6) As used in this section:

(a) "Contraband" has the meaning given that term in ORS 162.135.

(b) "Security reasons" means the protection of the mentally ill person from serious and immediate harm and the protection of others from threats or harassment as defined by rule of the department. [1967 c.460 §4; 1973 c.838 §28; 1981 c.372 §3; 1983 c.486 §1; 1993 c.442 §16; 1995 c.141 §1; 2001 c.104 §152]

426.390 Construction. Nothing in ORS 426.295, 426.297 and 426.380 to 426.390 is intended to detract from the powers of a court under ORS chapter 125 or ORS 179.640. [1967 c.460 §7; 1973 c.823 §137; 1995 c.664 §96]

426.395 Posting of statement of patient rights. A simple and clear statement of rights guaranteed to patients committed to the division shall be prominently posted in each room frequented by patients in all facilities housing such patients. A copy of the statement shall be given to each patient upon admission and sent, upon request, to the legal counsel, guardian, relative or friend of the patient. [1973 c.838 §31]

426.405 [1983 c.536 §1; repealed by 2001 c.900 §261]

426.407 [1983 c.536 §2; repealed by 2001 c.900 §261]

426.410 [1969 c.638 §1; repealed by 1975 c.690 §28]

(Licensing of Persons Who May Order Restraint or Seclusion)

426.415 Licensing of persons who may order and oversee use of restraint and seclusion in facilities providing mental health treatment to individuals under 21 years of age; rules. (1) The Director of Human Services may adopt rules establishing requirements and procedures for licensing persons who may order, monitor and evaluate the use of restraint and seclusion in facilities providing intensive mental health treatment services to individuals under 21 years of age.

(2) A license may not be issued or renewed under rules adopted under this section unless the person applying for the license or renewal:

(a) Is employed by or providing services under contract with a provider that is certified by the Department of Human Services to provide intensive mental health treatment services for individuals under 21 years of age;

(b) Has successfully completed an emergency safety intervention training program approved by the director;

(c) Provides documented evidence of the person's ability to assess the psychological and physical well-being of individuals under 21 years of age;

(d) Meets other qualifications established by the director by rule for qualified mental health professionals; and

(e) Demonstrates knowledge of federal and state rules governing the use of restraint and seclusion in intensive mental health treatment programs for individuals under 21 years of age.

(3) The rules described in subsection (1) of this section shall:

(a) Specify procedures for issuing and renewing licenses;

(b) Establish a term of licensure;

(c) Require a person issued a license to satisfy annual training requirements relating to emergency safety intervention procedures;

(d) Specify grounds for denial, suspension or revocation of a license;

(e) Set any license or renewal fees the director determines are necessary; and

(f) Specify any other licensing provisions the director determines are necessary to comply with federal law or regulations or to operate a licensing system described in this section. [2001 c.807 §1]

Note: 426.415 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 426 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

426.450 [1971 c.622 §6; renumbered 430.397 in 1995]

426.460 [1971 c.622 §7; 1973 c.795 §3; 1979 c.744 §22; 1981 c.809 §1; 1985 c.565 §68; renumbered 430.399 in 1995]

426.470 [1971 c.622 §8; renumbered 430.401 in 1995]

CHRONICALLY MENTALLY ILL PERSONS

(Generally)

426.490 Policy. It is declared to be the policy and intent of the Legislative Assembly that the State of Oregon shall assist in improving the quality of life of chronically mentally ill persons within this state by insuring the availability of an appropriate range of residential opportunities and related support services. [1979 c.784 §1]

Note: 426.490 to 426.500 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 426 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

426.495 Definitions for ORS 426.490 to 426.500. As used in ORS 426.490 to 426.500, unless the context requires otherwise:

(1) "Case manager" means a person who works on a continuing basis with the chronically mentally ill person and is responsible for assuring the continuity of the various services called for in the discharge plan of the chronically mentally ill person including services for basic personal maintenance, mental and personal treatment, and appropriate education and employment.

(2) "Chronically mentally ill" means an individual who is:

(a) Eighteen years of age or older; and

(b) Diagnosed by a psychiatrist, a licensed clinical psychologist or a nonmedical examiner certified by the Department of Human Services as suffering from chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder other than those caused by substance abuse. For purposes of providing services in the community, the department may adopt rules consistent with this section and accepted professional practices in the fields of psychology and psychiatry more specifically to specify other criteria for determining who is chronically mentally ill.

(3) "Discharge plan" means a written plan prepared jointly with the chronically mentally ill person, mental health staff and case manager prior to discharge, prescribing for the basic and special needs of the person upon release from the hospital. [1979 c.784 §2; 1987 c.903 §35]

Note: See note under 426.490.

426.500 Powers and duties of Department of Human Services. For the purpose of carrying out the policy and intent of ORS 426.490 to 426.500, the Department of Human Services shall:

(1) Adopt rules for the administration of ORS 426.490 to 426.500;

(2) Prepare a written discharge plan for each chronically mentally ill person who is a patient at a state mental institution or who is committed to the department pursuant to ORS 426.005 to 426.223 and 426.241 to 426.380;

(3) Ensure that case managers are provided for each chronically mentally ill person described in subsection (2) of this section; and

(4) Disburse from any available funds:

(a) Funds for one LINC model in the area served by F. H. Dammasch State Hospital

and one LINC model in the area served by the Oregon State Hospital licensed under ORS 443.415;

(b) Discretionary funds for services necessary to implement a discharge plan, including but not limited to transportation, medication, recreation and socialization; and

(c) Funds to provide day treatment services, community psychiatric inpatient services, and work activity services for chronically mentally ill persons where needed. [1979 c.784 §3; 1999 c.59 §121]

Note: See note under 426.490.

(Community Housing)

426.502 Definitions for ORS 426.502 to 426.508. As used in ORS 426.502 to 426.508:

(1) "Chronically mentally ill" has the meaning given that term in ORS 426.495.

(2) "Community housing" means property and related equipment that are used or could be used to house chronically mentally ill persons. "Community housing" includes only multiple-unit residential housing occupied by only chronically mentally ill persons.

(3) "Construct" means to build, install, assemble, expand, alter, convert, replace or relocate. "Construct" includes to install equipment and to prepare a site.

(4) "Department" means the Department of Human Services.

(5) "Equipment" means furnishings, fixtures or appliances that are used or could be used to provide care in community housing.

(6) "Multiple-unit residential housing" means housing that provides four or more living units and spaces for common use by the occupants in social and recreational activities. "Multiple-unit residential housing" may include nonhousing facilities incidental or appurtenant to the housing that, in the determination of the department, improve the quality of the housing. [1999 c.983 §2]

426.504 Authority of department to develop community housing for chronically mentally ill persons; sale of community housing; conditions. (1) The Department of Human Services may, through contract or otherwise, acquire, purchase, receive, hold, exchange, demolish, construct, lease, maintain, repair, replace, improve and equip community housing for the purpose of housing chronically mentally ill persons.

(2) The department may dispose of community housing acquired under subsection (1) of this section in a public or private sale, upon such terms and conditions as the department considers advisable to increase the quality and quantity of community housing available for chronically mentally ill persons. In any instrument conveying fee title to community housing, the department shall include language that restricts the use of the community housing to housing for chronically mentally ill persons. Such restriction is not a violation of ORS 93.270.

(3) When exercising the authority granted to the department under this section, the department is not subject to ORS chapter 273 or ORS 270.100 to 270.190, 276.900 to 276.915 or 279.800 to 279.833. [1999 c.983 §3]

426.506 Community Mental Health Housing Fund; Community Housing Trust Account; report. (1) There is created in the State Treasury, separate and distinct from the General Fund, the Community Mental Health Housing Fund. All earnings on investments of moneys in the Community Mental Health Housing Fund shall accrue to the fund. Interest earned on moneys in the fund shall be credited to the fund. All moneys in the fund are continuously appropriated to the Department of Human Services to carry out the provisions of ORS 426.504.

(2) The Community Mental Health Housing Fund shall be administered by the department to provide housing for chronically mentally ill persons. As used in this subsection, "housing" may include acquisition, maintenance, repair, furnishings and equipment.

(3)(a) There is established within the Community Mental Health Housing Fund a Community Housing Trust Account. Notwithstanding the provisions of ORS 270.150, the department shall deposit into the account the proceeds, less costs to the state, received by the department from the sale of F. H. Dammasch State Hospital property under ORS 426.508. The department may expend, for the purposes set forth in ORS 426.504, any earnings credited to the account, including any interest earned on moneys deposited in the account, and up to five percent of the sale proceeds initially credited to the account by the Oregon Department of Administrative Services. At least 95 percent of the sale proceeds shall remain in the account in perpetuity. Proceeds deposited in the account may not be commingled with proceeds from the sale of any surplus real property owned, operated or controlled by the Department of Human Services and used as a state training center.

(b) Interest earned on moneys in the Community Housing Trust Account may be expended in the following manner:

(A) Seventy percent of interest earned on deposits in the account shall be expended for community housing purposes; and

(B) Thirty percent of interest earned on deposits in the account shall be expended for institutional housing purposes.

(c) Interest earned on deposits in the account shall not be used to support operating expenses of the department.

(4) The Community Mental Health Housing Fund shall consist of:

(a) Moneys appropriated to the fund by the Legislative Assembly;

(b) Sale proceeds and earnings from the account under subsection (3) of this section;

(c) Proceeds from the sale, transfer or lease of any surplus real property owned, operated or controlled by the department and used as community housing;

(d) Moneys reallocated from other areas of the department's budget;

(e) Interest and earnings credited to the fund; and

(f) Gifts of money or other property from any source, to be used for the purposes of developing housing for chronically mentally ill persons.

(5) The department shall adopt policies:

(a) To establish priorities for the use of moneys in the Community Mental Health Housing Fund for the sole purpose of developing housing for chronically mentally ill persons;

(b) To match public and private moneys available from other sources for developing housing for chronically mentally ill persons; and

(c) To administer the fund in a manner that will not exceed the State Treasury's maximum cost per transaction.

(6) The Department of Human Services shall collaborate with the Housing and Community Services Department to ensure the highest return and best value for community housing from the Community Mental Health Housing Fund.

(7) The Department of Human Services shall provide a report of revenues to and expenditures from the Community Mental Health Housing Fund as part of its budget submission to the Governor and Legislative Assembly under ORS chapter 291. [1999 c.983 §4; 2001 c.954 §31]

426.508 Sale of F. H. Dammasch State Hospital; fair market value; redevelopment of property; property reserved for community housing. (1) Notwithstanding ORS 421.611 to 421.630 or any actions taken under ORS 421.611 to 421.630, the Department of Corrections shall transfer the real property known as the F. H. Dammasch State Hospital and all improvements to the Oregon Department of Administrative Services to be sold for the benefit of the Department of Human Services.

(2)(a) Notwithstanding ORS 270.100 to 270.190, and except as provided in subsection (4) of this section, the Oregon Department of Administrative Services shall sell or otherwise convey the real property known as the F. H. Dammasch State Hospital in a manner consistent with the provisions of this section. Conveyance shall not include transfer to a state agency. The sale price of the real property shall equal or exceed the fair market value of the real property. The Oregon Department of Administrative Services shall engage the services of a licensed real estate broker or principal real estate broker to facilitate the sale of the real property.

(b) The Oregon Department of Administrative Services shall retain from the sale or other conveyance of the real property those costs incurred by the state in selling or conveying the real property, including costs incurred by the Department of Corrections in transferring the real property to the Oregon Department of Administrative Services. The remaining proceeds from the sale or other conveyance shall be transferred to the Community Housing Trust Account created under ORS 426.506 (3).

(3) Redevelopment of the real property formerly occupied by the F. H. Dammasch State Hospital shall be consistent with the Dammasch Area Transportation Efficient Land Use Plan developed by Clackamas County, the City of Wilsonville, the Oregon Department of Administrative Services, the Department of Land Conservation and Development, the Department of Transportation, the State Housing Council, the Department of Human Services and the Division of State Lands.

(4) The Oregon Department of Administrative Services shall reserve from the sale of the real property under subsection (2) of this section not more than 10 acres. The real property reserved from sale shall be transferred to the Department of Human Services for use by the Department of Human Services to develop community housing for chronically mentally ill persons. The Oregon Department of Administrative Services and the Department of Human Services shall jointly coordinate with the City of Wilsonville to identify the real property reserved from sale under this subsection. [1999 c.983 §5; 2001 c.300 §76; 2001 c.900 §253]

Note: The amendments to 426.508 by section 76, chapter 300, Oregon Laws 2001, become operative July 1, 2002. See section 85, chapter 300, Oregon Laws 2001. The text that is operative until July 1, 2002, including amendments by section 253, chapter 900, Oregon Laws 2001, is set forth for the user's convenience.

426.508. (1) Notwithstanding ORS 421.611 to 421.630 or any actions taken under ORS 421.611 to 421.630, the Department of Corrections shall transfer the real property known as the F. H. Dammasch State Hospital and all improvements to the Oregon Department of Admin-

istrative Services to be sold for the benefit of the Department of Human Services.

(2)(a) Notwithstanding ORS 270.100 to 270.190, and except as provided in subsection (4) of this section, the Oregon Department of Administrative Services shall sell or otherwise convey the real property known as the F. H. Dammasch State Hospital in a manner consistent with the provisions of this section. Conveyance shall not include transfer to a state agency. The sale price of the real property shall equal or exceed the fair market value of the real property. The Oregon Department of Administrative Services shall engage the services of a licensed real estate broker or real estate organization to facilitate the sale of the real property.

(b) The Oregon Department of Administrative Services shall retain from the sale or other conveyance of the real property those costs incurred by the state in selling or conveying the real property, including costs incurred by the Department of Corrections in transferring the real property to the Oregon Department of Administrative Services. The remaining proceeds from the sale or other conveyance shall be transferred to the Community Housing Trust Account created under ORS 426.506 (3).

(3) Redevelopment of the real property formerly occupied by the F. H. Dammasch State Hospital shall be consistent with the Dammasch Area Transportation Efficient Land Use Plan developed by Clackamas County, the City of Wilsonville, the Oregon Department of Administrative Services, the Department of Land Conservation and Development, the Department of Transportation, the State Housing Council, the Department of Human Services and the Division of State Lands.

(4) The Oregon Department of Administrative Services shall reserve from the sale of the real property under subsection (2) of this section not more than 10 acres. The real property reserved from sale shall be transferred to the Department of Human Services for use by the Department of Human Services to develop community housing for chronically mentally ill persons. The Oregon Department of Administrative Services and the Department of Human Services shall jointly coordinate with the City of Wilsonville to identify the real property reserved from sale under this subsection.

SEXUALLY DANGEROUS PERSONS

426.510 "Sexually dangerous person" defined. As used in ORS 426.510 to 426.680, unless the context otherwise requires, "sexually dangerous person" means a person who because of repeated or compulsive acts of misconduct in sexual matters, or because of a mental disease or defect, is deemed likely to continue to perform such acts and be a danger to other persons. [1963 c.467 §1; 1977 c.377 §1]

426.520 [1963 c.467 §2; repealed by 1977 c.377 §6]

426.530 [1963 c.467 §3; 1971 c.743 §367; 1973 c.836 §349; repealed by 1977 c.377 §6]

426.540 [1963 c.467 §4; repealed by 1977 c.377 §6]

426.550 [1963 c.467 §5; repealed by 1977 c.377 §6]

426.560 [1963 c.467 §6; repealed by 1977 c.377 §6]

426.570 [1963 c.467 §7; 1973 c.836 §350; repealed by 1977 c.377 §6]

426.580 [1963 c.467 §§8,9; 1973 c.443 §1; repealed by 1977 c.377 §6]

426.590 [1963 c.467 §10; repealed by 1977 c.377 §6]

426.610 [1963 c.467 §11; 1973 c.443 §2; repealed by 1977 c.377 §6]

426.620 [1963 c.467 §12; repealed by 1977 c.377 §6]

426.630 [1963 c.467 §13; repealed by 1977 c.377 §6]

426.640 [1963 c.467 §14; 1973 c.443 §3; 1975 c.380 §8; repealed by 1977 c.377 §6]

426.650 Voluntary admission to state institution. (1) Pursuant to rules promulgated by the Department of Human Services, the superintendent of any state hospital for the treatment and care of the mentally ill may admit and hospitalize therein as a patient any person in need of medical or mental therapeutic treatment as a sexually dangerous person who voluntarily has made written application for such admission. No person under the age of 18 years shall be admitted as a patient to any such state hospital unless an application therefor in behalf of the person has been executed by the parent, adult next of kin or legal guardian of the person. Pursuant to rules and regulations of the department, no person voluntarily admitted to any state hospital shall be detained therein more than 72 hours after the person, if at least 18 years of age, has given notice in writing of desire to be discharged therefrom, or, if the patient is under the age of 18 years, after notice in writing has been given by the parent, adult next of kin or legal guardian of the person that such parent, adult next of kin or legal guardian desires that such person be discharged therefrom.

(2) Any person voluntarily admitted to a state facility pursuant to this section may upon application and notice to the superintendent of the institution concerned, be granted a temporary leave of absence from the institution if such leave, in the opinion of the chief medical officer, will not interfere with the successful treatment or examination of the applicant. [1963 c.467 §15; 1969 c.391 §8; 1973 c.443 §4; 1973 c.827 §43; 1974 c.36 §11]

426.660 [1963 c.467 §16; repealed by 1973 c.443 §5]

426.670 Treatment programs for sexually dangerous persons. The Department of Human Services hereby is directed and authorized to establish and operate treatment programs, either separately within an existing state Department of Corrections institution, as part of an existing program within a Department of Human Services institution, or in specified and approved sites in the community to receive, treat, study and retain in custody, as required, such sexually dangerous persons as are committed under ORS 426.510 to 426.670. [1963 c.467 §17; 1965 c.481 §1; 1979 c.606 §1; 1987 c.320 §230]

426.675 Determination of sexually dangerous persons; custody pending sentencing; hearing; sentencing; rules. (1) When a defendant has been convicted of a sexual offense under ORS 163.305 to 163.467 or 163.525 and there is probable cause to believe the defendant is a sexually dangerous

person, the court prior to imposing sentence may continue the time for sentencing and commit the defendant to a facility designated under ORS 426.670 for a period not to exceed 30 days for evaluation and report.

(2) If the facility reports to the court that the defendant is a sexually dangerous person and that treatment available may reduce the risk of future sexual offenses, the court shall hold a hearing to determine by clear and convincing evidence that the defendant is a sexually dangerous person. The state and the defendant shall have the right to call and cross-examine witnesses at such hearing. The defendant may waive the hearing required by this subsection.

(3) If the court finds that the defendant is a sexually dangerous person and that treatment is available which will reduce the risk of future sexual offenses, it may, in its discretion at the time of sentencing:

(a) Sentence the defendant to probation on the condition that the person participate in and successfully complete a treatment program for sexually dangerous persons pursuant to ORS 426.670;

(b) Impose a sentence of imprisonment with the order that the defendant be assigned by the Director of the Department of Corrections to participate in a treatment program for sexually dangerous persons pursuant to ORS 426.670. The Department of Corrections and Department of Human Services shall jointly adopt administrative rules to coordinate assignment and treatment of prisoners under this subsection; or

(c) Impose any other sentence authorized by law. [1977 c.377 §3; 1979 c.606 §2; 1987 c.320 §231; 1993 c.14 §24]

426.680 Trial visits for probationer. (1) The superintendent of the facility designated under ORS 426.670 to receive commitments for medical or mental therapeutic treatment of sexually dangerous persons may grant a trial visit to a defendant committed as a condition of probation where:

(a) The trial visit is not inconsistent with the terms and conditions of probation; and

(b) The trial visit is agreed to by the community mental health and developmental disabilities program director for the county in which the person would reside.

(2) Trial visit here shall correspond to trial visit as described in ORS 426.273 to 426.292, except that the length of a trial visit may be for the duration of the period of probation, subject to the consent of the sentencing court. [1973 c.443 §7; 1977 c.377 §4; 1985 c.242 §7]

426.700 [1973 c.616 §1; repealed by 1981 c.372 §2]

426.705 [1973 c.616 §2; repealed by 1981 c.372 §2]

426.710 [1973 c.616 §6; repealed by 1981 c.372 §2]

426.715 [1973 c.616 §7; repealed by 1981 c.372 §2]

426.720 [1973 c.616 §8; repealed by 1981 c.372 §2]

426.725 [1973 c.616 §9; repealed by 1981 c.372 §2]

426.730 [1973 c.616 §10; repealed by 1981 c.372 §2]

426.735 [1973 c.616 §11; repealed by 1981 c.372 §2]

426.740 [1973 c.616 §12; repealed by 1981 c.372 §2]

426.745 [1973 c.616 §§13,14,15; repealed by 1981 c.372 §2]

426.750 [1973 c.616 §3; repealed by 1981 c.372 §2]

426.755 [1973 c.616 §4; repealed by 1981 c.372 §2]

426.760 [1977 c.148 §5; repealed by 1981 c.372 §2]

Gold Award

A Model for Management and Treatment of Insanity Acquittees

Psychiatric Security Review Board, State of Oregon

In the mid 1970s, both the public and the mental health professions in Oregon were concerned about the threat to the public presented by persons found not guilty of crimes due to insanity who were released from psychiatric hospitals. In addition, the forensic unit of the state mental hospital was overcrowded with insanity acquittees, but there were few community programs to supervise or treat dangerous mentally ill offenders who might be released.

At the same time, increased attention to the rights of mentally ill patients in the 1960s and 1970s had led to due-process reforms that made it difficult to legally detain mentally ill persons. The state often used procedures for insanity acquittees similar to those used for civilly committed persons—short hospital stays with little or no community monitoring. Existing laws placed authority for disposition of insanity acquittees on the criminal courts, which often lacked the time, resources, or expertise to make informed judgments about an individual's clinical condition or dangerousness to others.

To address these problems, the state of Oregon in 1978 established the Psychiatric Security Review Board, an independent, interdisciplinary program for monitoring persons who are found guilty except for insanity and who are considered to present a substantial danger to others. In recognition of its commitment to improved integration of mental health services within the criminal justice system and its responsibility to community and societal values, the State of Oregon's Psychiatric Security Review Board was selected to receive the 1994 Gold Achievement Award from the Hospital and Community Psychiatry Service of the American Psychiatric Association. The award is presented each year to recognize outstanding programs for mentally ill and developmentally disabled persons. It includes a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals. The award was presented October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego.

The primary purpose of the Psychiatric Security Review Board, which is the first program of its kind in the United States, is to protect society through the postadjudication management and treatment of insanity acquittees, almost all of whom are chronically mentally ill. The board assumes sole authority for determining whether persons assigned by the courts to its jurisdiction should be committed to the state hospital, granted conditional release or have conditional release revoked, or be discharged from the board's authority if they are no longer mentally ill and dangerous to others. Unless discharged early, an insanity acquittee remains under the board's jurisdiction for the maximum sentence that could have been received if the person had been convicted. The program's conditional release component provides a mechanism for reducing the number and length of costly inpatient stays.

The Psychiatric Security Review Board successfully bridges the mental health and criminal justice systems, while acting independently of both systems. Persons come under the jurisdiction of the board through the courts and are treated and supervised by staff from the mental health system. About 65 new persons are placed under the board's jurisdiction each year. Currently the board is responsible for about 500 people, 180 of whom are on conditional release. In a study of criminal recidivism among 366 subjects who were conditionally released between 1978 and 1986, only 15 percent were rearrested while on conditional release.

Oregon's Psychiatric Security Review Board has received highly favorable attention from national organizations, including the endorsements of the American Psychiatric Association and the National Alliance for the Mentally Ill. Two other states—Connecticut and Utah—have established review boards that substantially replicate the Oregon program. The board's continued vitality during a period of budget constraints, legal assaults on mental health systems, and public opinion favoring abolishment of the insanity defense attests to the confidence it has inspired among defense and prosecuting attorneys, judges, mental health professionals, and the citizens of Oregon.

Organization of the board

Oregon's Psychiatric Security Review Board functions independently of the court system and the Oregon Mental Health and Developmental Disability Services Division, although it closely coordinates its activities with the mental health division, which provides treatment to insanity acquittees.

The board effectively integrates the disciplines of law, psychiatry, psychology, and social work. By law, two of its five part-time members must be a psychiatrist and a psychologist experienced in the criminal justice system, one an experienced parole and probation officer, one an attorney experienced in criminal trial practice, and one a member of the general public. The psychiatrist and the psychologist cannot be employees of the state mental health division. The attorney cannot be a district attorney or public defender. The board members receive per diem expenses for their meetings.

Board members are appointed by the governor and confirmed by the state senate for four-year terms. The current members are George Saslow, M.D., Stephen Scherr, Ph.D., Kim Drake (parole and probation officer), Hilda Galaviz-Stoller, J.D., and Vern Faatz (public member).

The board has four staff positions—an executive director, two administrative assistants, and a secretary. Mary Claire Buckley, J.D., an attorney with mental health law experience in both civil and criminal commitments, serves as executive director. Staff duties include working with the staff of Oregon State Hospital in Salem, which provides inpatient services for persons under the board's jurisdiction; with members of the bar; with staff of community mental health agencies; and with victims and families of insanity acquittees.

The board operates on a biennial budget, with funds appropriated by the Oregon state legislature. Current funding, approved through mid-1995, for administrative costs associated with operation of the board is about $630,000 for the two-year period. The Oregon Mental Health and Developmental Disability Services Division provides the funds for community care of insanity acquittees on conditional release. The division contracts with public and private agencies to provide a range of mental health services.

The basic cost for community supervision of an insanity acquittee is about $5,000 per year. The cost for acquittees who need enhanced outpatient services is about $9,000 per year and for the few who need extensive residential placement services, about $33,000 per year. These totals compare with an annual cost of $60,130 for inpatient care.

The 1994 H&CP Achievement Award Winners

The American Psychiatric Association honored five outstanding mental health programs in an awards presentation on October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego. The Psychiatric Security Review Board of the State of Oregon received the Gold Award and a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals.

Four programs received certificates of significant achievement. They are the Alternative Family Program of Gulf Coast Community Care in Clearwater, Florida, the Emory Autism Resource Center in Atlanta, Evolving Consumer Households of the Massachusetts Mental Health Center in Boston, and Independence Center in St. Louis.

The winning programs were chosen from among 52 applicants by the 1994 H&CP Achievement Awards board, which was chaired by Don R. Lipsett, M.D., of Cambridge, Massachusetts. The awards have been presented annually since 1949. Descriptions of this year's winning programs are included in this issue, beginning on page 1127.

Population served

Since the 1970s, the clinical characteristics of insanity acquittees have become increasingly homogeneous due to adoption of more restrictive definitions of the insanity defense. For example, in 1983 Oregon eliminated the insanity defense for people with a sole diagnosis of personality disorder. Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness, primarily schizophrenia or other psychosis, and have extensive past experience with both the mental health and the criminal justice systems. The persons for whom the board is responsible are often the sickest patients in the population of chronic mentally ill persons.

In a sample of 758 persons assigned to the jurisdiction of the Psychiatric Security Review Board between 1978 and 1986, almost 90 percent were men, and half were between the ages of 20 and 30. Most were white, in keeping with the ethnic distribution of Oregon's population. They were generally unemployed or underemployed and either lived alone, with family, or in protected settings.

More than three-quarters of the group had a previous state hospital stay. The group as a whole had a mean of 3.1 prior psychiatric hospitalizations, 59 percent of them involuntary. Psychosis accounted for 72 percent of diagnoses—60 percent of the group had a diagnosis of schizophrenia, and 7 percent had bipolar disorder. Eleven percent had a personality disorder, 8 percent had mental retardation, and 5 percent had organic mental disorders. Substance abuse disorders accounted for only 3 percent of primary diagnoses, but 27 percent of the group had substance abuse problems.

The group had extensive involvement with the criminal justice system—a mean of 5.5 police contacts per person—before being assigned to the board's jurisdiction. Seventy-seven percent of the sample had previously been charged with criminal offenses. Seventy-three percent were assigned to the board's jurisdiction after charges involving felonies, and 27 percent after misdemeanors. The most frequently occurring felonies were assaults, burglaries, and unauthorized use of motor vehicles. Harassment was the most frequently occurring misdemeanor. Cases resulting in death of another—murder or manslaughter—accounted for 4 percent of the crimes.

How the board operates

Board powers. The Psychiatric Security Review Board was created by 1977 legislation—Oregon Revised

statutes, Sections 161.319–161.351, 161.385–161.395 (1977)—which transferred legal responsibility for many acquittees from the trial courts to the board as of January 1, 1978. The statute specifies that the primary concern of the board is protection of the public and gives the board sole authority for determining the placement of persons assigned to its jurisdiction.

To counterbalance these stipulations, the law provided substantial legal safeguards to persons under the board's jurisdiction, including rights to periodic hearings, legal representation at all hearings, cross-examination, subpoena power, independent professional evaluation before hearings, and appeal of the board's decisions to the Oregon appellate courts.

A key innovation is development of a well-supervised conditional release for insanity acquittees that covers both the individual's readiness for release and the availability of supervision and treatment in the community. The system allows for protection of the civil liberty interests of insanity acquittees by developing treatment in the least restrictive setting that is appropriate for each acquittee. The board may promptly revoke conditional release if it receives reports that the individual has violated the release conditions or that the individual's mental status has deteriorated. However, once a person is discharged from the board's jurisdiction, neither the trial court nor the board has any continuing authority over that person.

The board is a state agency administratively located within the Department of Administrative Services. Because authority over insanity acquittees is centralized in the board, which has specialized knowledge of the patient population and the care available for them, the state's interest in consistent application of rules and resources can be more easily accommodated than when decisions are made by a diverse group of trial court judges.

Commitment to the board's jurisdiction. Insanity defense cases in Oregon use a standard to define insanity that is based on the American Law Institute test. In 1983 the state changed the name of the plea used for insanity defense cases from "not responsible due to mental disease or defect" to "guilty except for insanity." A successful insanity defense initiates the Psychiatric Security Review Board's procedures for managing insanity acquittees.

After a finding of guilty except for insanity, the trial judge decides if the evidence shows that the defendant continues to be affected by a mental disease or defect and if the person presents a substantial danger to others. If the answer to either question is no, the state's jurisdiction terminates and the defendant is discharged; however, this outcome is relatively rare. The vast majority are not set free but are subject to management by the Psychiatric Security Review Board, which includes the probability of confinement and close supervision for an extended period of time.

> Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness and extensive past experience with both the mental health and the criminal justice systems.

The trial court judge determines the maximum length of this period based on the sentence the individual would have received if found criminally responsible for the offense. This time period is known in Oregon as the "insanity sentence," which ranges from year for a misdemeanor to a lifetime for murder. The court may assign individuals with multiple charges to the board's jurisdiction for longer periods reflecting consecutive sentencing.

The trial judge also determines whether there is a victim of the defendant's crime and whether the victim wishes to be notified if the board decides that the insanity acquittee will be conditionally released or discharged or if the acquittee escapes from supervision. If so, the board must make reasonable efforts to notify the victim of these events. Finally, the trial court judge determines whether the insanity acquittee will be initially placed in the forensic unit of the state hospital or in the community on conditional release.

Hearings. Insanity acquittees serve their "insanity sentence" within the mental health system either in the state hospital or in the community in a monitored conditional release program. The Oregon statutes require the Psychiatric Security Review Board to conduct periodic hearings for each individual it supervises. Each person is eligible for a hearing every six months. Insanity acquittees, hospital staff, and staff of community monitoring agencies may also request hearings. The board conducts about 300 full hearings each year.

Hearings are held once a week at Oregon State Hospital. Relaxed rules of evidence provide a less stringent burden of proof than in civil commitment hearings and allow board members to consider proceedings of the acquittee's trial, information submitted by interested parties, and the acquittee's entire psychiatric and criminal history.

During the days before the hearings, the board's staff compiles and provides to board members documents about the case, which may consists of several hundred pages. Over the last five years, the board has become more efficient in conducting hearings by employing a case summary coordinator to computerize records and then to index them for board members.

At least three board members must be present for a hearing. The state is represented by an assistant attorney general or local district attorney. The insanity acquittee has a right to legal counsel, and indigent persons are provided counsel without cost. Psychiatrists, social workers, and psychologists from the state hospital staff testify regarding the acquittee's mental health status and progress. The acquittee is present and can subpoena and cross-examine witnesses. All hearings are recorded,

and the transcript constitutes the record if the person decides to appeal the board's decision to the appellate court.

The burden of proof on all issues is by a preponderance of the evidence. The state bears the burden of persuasion in all hearings except those held to consider an acquittee's application for change of status, in which the person must prove his or her suitability for release or discharge.

All three board members must vote unanimously for a decision to be made at the hearing. If a consensus decision cannot be reached, the case file and transcript of the hearing are referred to the two board members who were not present and three of the five members must concur. At the conclusion of the hearing, the board's chair or acting chair gives the insanity acquittee and the attorney written notification advising of the right to appeal an adverse decision within 60 days from the date an order is signed. The board must provide a written order within 15 days of the hearing.

The board also conducts administrative hearings in which an insanity acquittee's conditional release or treatment plan is reviewed or modified. The acquittee does not have to be present for such hearings.

Hospitalization, conditional release, and discharge. Hospital care for insanity acquittees is provided at the Oregon State Hospital forensic unit in Salem. Almost 525 of the 700 beds at the state hospital are devoted to patients under the board's jurisdiction. The patient's treatment plan is developed by hospital staff, but major alterations in the plan, such as off-campus passes, must be approved by the Psychiatric Security Review Board.

Some patients who are assigned to the board's jurisdiction cannot be released into the community under any foreseeable conditions. But for others, conditional release is a reasonable prospect, provided they are closely monitored and supervised by mental health programs in the community. Community programs for insanity acquittees have been influenced by many of the major reforms that took place in community mental health in general in the late 1970s and early 1980s, particularly a refocusing on the needs of chronic mentally ill patients who were being discharged from state mental hospitals. In 1981 Oregon legislation recognized chronic mentally ill people as the population with the highest priority for public mental health services and reorganized community mental health programs to emphasize support services for them. Within this reorganization, a separate component for community services for released insanity acquittees was created.

The patient, the patient's attorney, or hospital staff members may file a request for conditional release. A patient may request a hearing for the board to consider conditional release every six months. The board then has 60 days within which to set that hearing. Hospital staff may submit a request for conditional release of a patient at any time. Those hearings are set as soon as possible.

At the board's request, a community program conducts a thorough evaluation of each insanity acquittee being considered for release. State law prohibits conditional release until the community program, in cooperation with the board, develops a plan to provide adequate supervision and treatment. The conditional release plan constitutes an agreement among the board, the Mental Health and Developmental Disability Services Division, the community program, and the insanity acquittee. The plan includes provisions for living arrangements, mental health aftercare, and case management.

The plan may specify that the acquittee reside in a specific group home and not change residence without approval of the case manager. He or she may be required to take medication under observation of group home staff, to attend a day treatment program, and to submit to drug screening and medical monitoring. The plan may also stipulate additional conditions; for example, the person may be prohibited from driving, using alcohol or other drugs, or contacting certain persons.

The board designates a particular person, usually the case manager, to monitor the insanity acquittee's progress and make reports to the board monthly or at any time the conditions of the release are violated or the acquittee's mental status changes. In addition, any police contact with the conditionally released person, even if he or she is a victim of a crime, is immediately reported to the board via the law enforcement data system computer. The community program usually reports to the board by telephone if a problem arises requiring prompt board action. On receipt of such a report, the board or its chairperson may immediately issue a written order revoking conditional release. This order constitutes a sufficient warrant for the police to take the person into custody. The person may not be jailed, but must be transported to the state hospital.

The entire process from report to rehospitalization may be accomplished within a few hours. The board must then hold a hearing within 20 days to decide if the person should remain committed to the hospital, return to conditional release, or be discharged. Data on persons under the board's jurisdiction before 1986 showed that although more than half of those on conditional release had their release revoked within a year, only a few revocations were due to new criminal charges. Most occurred because of violations of conditions of release such as a requirement to take medication or refrain from using alcohol or because of deteriorating mental health.

Persons may be discharged from the board's jurisdiction while in the hospital or on conditional release. At any hearing, the board must discharge a person found to be no longer affected by mental disorder or no longer presenting a substantial danger to others. Thus both criteria—mental disease or defect and dangerousness—must be met for the board to retain jurisdiction. A person is automatically discharged after having been under the board's jurisdiction for the duration of the "insanity sentence." At the end of the insanity sentence, the state has the option of instituting civil commitment procedures to retain custody of a person believed to meet criteria for civil commitment.

Research on outcomes

The Psychiatric Security Review Board monitors its own performance as well as that of the insanity acquittees it supervises. Quality improvement mechanisms include a full financial audit done by the Secretary of State's audit division every four years and an internal quarterly review using a productivity matrix developed by the board's staff. Performance measures (and their averages since 1992) include percentage of hearings held within statutory time limits (85.7 percent), percentage of conditional releases maintained per month (95.7 percent), and percentage of revocations based on new felonies (1.7 percent).

The board's centralized record keeping system has provided opportunities for extensive research on the characteristics of the forensic population and on service outcomes. Joseph Bloom, M.D., professor and chairman of the department of psychiatry at Oregon Health Sciences University, and his colleagues Douglas A. Bigelow, Ph.D., Bentson H. McFarland, M.D., Ph.D., Jeffrey Rogers, J.D., and Mary H. Williams, M.S., J.D., have studied various aspects of the Psychiatric Security Review Board's operation since its inception. A study funded by the National Institute of Mental Health developed in-depth information about a cohort of 758 persons assigned to the board's jurisdiction between 1978 and 1986, including data on their management while under the board's jurisdiction and on their involvement with the mental health and criminal justice systems after discharge.

The results showed that the system tended to use conditional release conservatively, in keeping with its mandate to protect the public; 68 percent of the study sample spent their entire insanity sentence or the entire study period in the hospital. Women were more likely than men to be conditionally released, as were subjects with fewer past contacts with the mental health and criminal justice systems and less serious crimes leading to board jurisdiction. Subjects whose conditional release was revoked tended to be younger, to have more extensive histories of substance abuse and of contact with the mental health and criminal justice systems, and to have spent more time in the hospital before conditional release. Follow-up an average of 53 months after subjects were discharged from the board's jurisdiction showed a significant decrease in the number of criminal justice contacts per year compared with the period before subjects became the board's responsibility. Among subjects who were arrested after discharge from the board's jurisdiction, there was an overall decrease in the number of felonies and an increase in the number of misdemeanors, compared with the period before board jurisdiction.

Plans for the future

The Psychiatric Security Review Board intends to continue to seek ways to increase its efficiency without jeopardizing its effectiveness. Current plans include training in administrative law procedure for board members and advanced training in computer technology for staff.

Staff of the Psychiatric Security Review Board also plan to increase efforts to fight state budget cuts that may threaten the board's existence. Adequate funding for the program beyond 1995 is not assured, as the final phase of a state initiative limiting the use of property tax revenue for government operations will go into effect that year. Staff plan to work with community organizations such as the Friends of Forensic, consisting of people with relatives and friends under supervision of the board, and the National Alliance for the Mentally Ill to mobilize support for continuing the board's mission of protecting public safety while promoting cost-effective supervision and treatment of mentally ill persons who commit crimes.

For more information, contact Mary Claire Buckley, J.D., Executive Director, Psychiatric Security Review Board, 620 Southwest Fifth, Number 907, Portland, Oregon 97204; telephone, 503-229-5596.

Applications for 1995 Achievement Awards

The Hospital and Community Psychiatry Service of the American Psychiatric Association is now accepting applications for the 1995 Achievement Awards. The awards will be presented at the Institute on Psychiatric Services (the new name for the Institute on Hospital and Community Psychiatry), to be held October 6–10, 1995, in Boston. The deadline for receipt of applications is January 6, 1995.

The American Psychiatric Association presents the awards each year to recognize programs that have made an outstanding contribution to the mental health field, that provide a model for other programs, and that have met challenges presented by limited financial or staff resources or other significant obstacles.

The winner of the first prize, the Gold Award, receives a $10,000 grant from Roerig, a division of Pfizer Pharmaceuticals. If more than one program is chosen as a Gold Award winner, the programs share the grant. The winner of the Gold Award also receives a plaque, and the winners of Significant Achievement Awards receive certificates.

Applicants should submit six copies (including the original) of a completed application form and a program description. Each program that applies will be visited by a representative of the local district branch of the American Psychiatric Association. The site visitor's evaluation will assist the Achievement Awards board in selecting the winning programs.

Ricardo P. Mendoza, M.D., of Torrance, California, is chair of the 1995 Achievement Awards board. To receive an application form or additional information, write Achievement Awards, APA, 1400 K Street, N.W., Washington, D.C. 20005, or telephone 202-682-6174.

PSRB EPR ENTRY

0028 05/04/01 11:08 (54MF) ** PAGE 01 **

REUR 0027 LEDS
QLW.OR026035C.LNU/W093003945

*** NOT A WARRANT ***
PSYC SECURITY REVIEW BD-COND'L RELEASE (BASED ON LNU)
EPR OR026035C NAM/A_____ ,J____ L___ .M.W. .05-09-1960
HGT/508 WGT/145 EYE/BLU HAI/BRO
OCA/82-515
FBI/_____ SID/_____ SOC/_____
OLN/ .OR.2000
OFF/1399 OFN/ATT ASSAULT I RTP/PCR DOE/03-26-2008
MIS/---N0TIFY PRB 0F ALL INQUIRIES BY AM MSG---0R CALL L0CAL MENTAL HEALTH
W0RKER L____ C_____ AT 541-7__-2___ X592
ENT: 09-25-1998 AT 1625 FROM MF BY/PSYC SECURITY REVIEW B0ARD (PRB)
UPD: 04-27-2001 AT 1008 FROM PRB1
LNU/W093003945

-- IF ENFORCEMENT ACTION IS TAKEN AGAINST THIS PERSON SEND A MESSAGE TO 'PRB'

** NO MORE PAGES **

PSRB ORDER OF REVOCATION (EIP ENTRY) - RESPONSE TO WARRANTS CHECK

0014 05/04/01 10:47 (54MF) ** PAGE 01 **

REUR 0013 LEDS
QW.OR026035C.DOB/010140.NAM/TEST,PSRB

NO CRIMINAL WARRANT

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO
OREGON STATE HOSPITAL. AUTHORITY ORS 161.336 (5)

(BASED ON DOB,NAM)
EIP OR026035C NAM/TEST,PSRB .F.W.OR.01-01-1940
HGT/600 WGT/200 EYE/BRO HAI/BRO
OCA/01-TEST
DOR/05-07-2001 RTP/PRB
MIS/TEST ONLY--HIT CONFIRMATION 503-945-2800--TAKE TO OREGON STATE HOSPITAL
2600 CENTER ST NE SALEM
ENT: 05-04-2001 AT 1045 FROM PRB1 BY/PSYC SECURITY REVIEW BOARD (PRB)
LNU/W033426754

** NO MORE PAGES **

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PSRB MESSAGE SENT TO LAW ENFORCEMENT DISPATCH

009 05/04/01 10:55 (54MG)

0022 PRB OR026035C 05/04/01 10:55 (54MF)
OR PSYCHIATRIC RV BD

THE PSYCHIATRIC SECURITY REVIEW BOARD HAS ISSUED AN ORDER OF REVOCATION
AS FOLLOWS:

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO
OREGON STATE HOSPITAL. AUTHORITY ORS 161.336 (5)

(BASED ON LNU)
EIP OR026035C NAM/TEST,PSRB .F.W.OR.01-01-1940
HGT/600 WGT/200 EYE/BRO HAI/BRO
OCA/01-TEST
DOR/05-07-2001 RTP/PRB
MIS/TEST ONLY--HIT CONFIRMATION 503-945-2800--TAKE TO OREGON STATE HOSPITAL
2600 CENTER ST NE SALEM
ENT: 05-04-2001 AT 1045 FROM PRB1 BY/PSYC SECURITY REVIEW BOARD (PRB)
LNU/W033426754

PLEASE ATTEMPT TO TAKE THE SUBJECT INTO CUSTODY AT 123 S.E. FOURTH, PORTLAND, THE FOURTH STREET GROUP HOME. THE STAFF TELEPHONE NUMBER AT THE GROUP HOME IS 503-222-3333. THE SUBJECT'S MENTAL HEALTH CASE MANAGER AT NETWORK IS JOHN DOE (503-111-5555). THE SUBJECT MUST BE TRANSPORTED TO OREGON STATE HOSPITAL, 2600 CENTER ST NE, SALEM, PER THE ABOVE ENTRY.

MARY CLAIRE BUCKLEY
PSYCHIATRIC SECURITY REVIEW BOARD
503-229-5596 (8AM-5PM WEEKDAYS) -- FOR AFTER HOURS HIT CONFIRMATION CALL
OREGON STATE HOSPITAL AT 503-945-2800

EOT *** *** ***

ORS 161.336(6)

The community mental health and developmental disabilities program director, the director of the facility providing treatment to a person on conditional release, any peace officer or any person responsible for the supervision of a person on conditional release may take a person on conditional release into custody or request that the person be taken into custody if there is reasonable cause to believe the person is a substantial danger to others because of mental disease or defect and that the person is in need of immediate care, custody or treatment. Any person taken into custody pursuant to this subsection shall immediately be transported to a state hospital designated by the Mental Health and Developmental Disability Services Division. A person taken into custody under this subsection shall have the same rights as any person appearing before the board pursuant to ORS 161.346.

Oregon
John A. Kitzhaber, M.D., Governor

Psychiatric Security Review Board
620 SW Fifth, Suite 907
Portland, OR 97204
(503) 229-5596
FAX (503) 229-5085
E-mail psrb@OregonVOS.net

HISTORY AND FUNCTIONING

OF THE

PSYCHIATRIC SECURITY REVIEW BOARD

I. Oregon's "Not Guilty by Reason of Insanity" Defense prior to the Psychiatric Security Review Board

A. Prior to 1971 Legislature:

A person who pled not guilty to a crime due to mental disease or defect in Oregon (NGI-not guilty by reason of insanity), had the burden of proving by a preponderance of the evidence that he/she was unable to distinguish right from wrong as a consequence of mental disease or defect. (Modified M'Naughton Rule)

B. 1971-1975:

In 1971, the Oregon Legislature passed a new "NGI" statute which used the American Law Institute Model Penal Code (ALI) view of criminal responsibility. The accused was found not responsible if suffering from a mental disease or defect and lacking the substantial ability to understand the nature of the act or to conform the conduct to the requirements of the law. The trial court then had three alternatives: The court could commit the person found "NGI" to the Mental Health Division for care, custody and treatment at the Oregon State Hospital; the court could oversee the supervision of the person in a manner similar to court probation; or the person could be released from supervision by the court.

When the court committed the "NGI" person to the Mental Health Division, the person remained at the state hospital until such time as the superintendent recommended to the trial court that the person was ready for release. The trial court then would hold a hearing and, where appropriate, the court could release the "NGI" person subject to conditions. When release was not appropriate, the court issued a new order of commitment. In no case was an "NGI" case to go longer than five years without a hearing for review.

By 1975, in response to concerns voiced by mental health professionals and trial judges, two task forces were appointed to investigate Oregon's criminal responsibility law and the impact of this law on the mental health system and the corrections system. A legislative package which became Oregon House Bill 2382 was compiled with the aim of solving some of the problems inherent in the 1971 statute.

II. 1977: Creation of the Psychiatric Security Review Board

Prior to the enactment of House Bill 2382 (ORS Chapter 161) by the 1977 Legislature, the trial court had the mandate to continue supervising "NGI" persons after sentencing. The court had neither the funds available nor adequate personnel to provide the needed supervision. Judges quickly discovered that they were unable to spend the time necessary to track "NGI" persons who were in the community, while attempting to carry a trial judge's case load. This was clearly evident by the difficulty in obtaining and locating persons under the Board's jurisdiction once the law went into effect in January, 1978.

As of January 1, 1978, supervision of all currently adjudicated "NGI" persons was transferred from the court to the Board. Insanity defense cases in which the court found the person suffered from mental disease or defect and presented a substantial danger were put under the jurisdiction of the Psychiatric Security Review Board (PSRB). The Board works cooperatively with, but independently of, the judicial and mental health systems. The Board's jurisdiction over persons using the insanity defense runs from the day of sentencing and, unless terminated early, continues for the maximum period of time the person could have been sentenced had the person been found guilty of the crime charged. Sentencing guidelines do not apply to these cases. Jurisdiction would be terminated early if the client no longer suffered from a mental disease or defect or no longer presented a substantial danger to others. An individual under the Board's jurisdiction receives credit for time served pursuant to the charge; time spent on unauthorized leave from the state hospital is added on to the jurisdictional maximum.

III. Legislative Changes to the Insanity Defense Since Inception

A. 1981 Legislation:

1. The major change to the statute was the deletion of persons from the Board who were classified solely a "danger to self."

2. Also built into the original statute was a "sunset" provision which stated that unless the Legislature in the 1981 session took affirmative action, the PSRB would cease to function on July 1, 1981, and its responsibilities and jurisdiction in insanity cases would revert to the committing judges. The Board was continued by the 1981 Legislature.

B. 1983 Legislation:

Major changes were proposed to the insanity defense and although a few were made none altered the basic functioning of the Board. The following changes were made:

1. The nomenclature was changed from "not responsible due to mental disease or defect" to "guilty except for insanity." The name change did not affect the insanity defense itself.

2. The definition of mental disease or defect in ORS 161.295(2) presently does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, and the Legislature added "nor do they include any abnormality constituting solely a personality disorder."

3. ORS 162.155(1)(d) was amended to allow for extradition of a person under the jurisdiction of the Psychiatric Security Review Board who leaves the state without authorization of the Board.

4. Jury instructions were developed on the issue of insanity.

5. The district attorney of each county would submit to the state court administrator statistical records containing information relating to the assertion and trial of mental disease or defect defenses under ORS 161.295 and 161.305.

C. 1985 Legislation:

1. A person on conditional release who leaves the state without authorization may be prosecuted for escape in the second degree. This provision expands the scope of prosecution for the crime of escape in the second degree to those persons on conditional release.

2. If it has been more than two years since a person under the Board's jurisdiction has had a hearing in which the burden of proof was on the state, then the burden shall be on the state. Thus, persons who regularly request hearings will not be penalized for exercising their statutory rights.

D. 1987 Legislation:

1. The Board members' per diem was increased to $212 with adjustments according to the executive pay plan. It is currently $283.55.

2. The timing of a revocation hearing was changed to 20 days from the date the person is returned to the custody of the Mental Health Division. It had been 20 days from the date of the revocation order.

E. 1989 Legislation:

The five-year hearing for persons in the custody of the Mental Health Division was eliminated. Persons on conditional release continue to receive this statutory hearing. Individuals in the state hospital have a statutory hearing every two years.

F. 1991 Legislation:

The time period within which the Attorney General has to review a conditional release plan drafted by hospital and community staff for those PSRB clients seeking release from the hospital was shortened from not less than 30 days to not less than 20 days prior to PSRB hearing.

G. 1993 Legislation:

Sex offender registration requirements were expanded to include persons found guilty except for insanity of certain enumerated sex offenses. When a Psychiatric Security Review Board client is discharged or placed on conditional release, Board staff shall enter the person's name and description, the description of the methodology of the offense and the address where the person expects to reside into the Law Enforcement Data System (LEDS).

H. 1995 Legislation:

The time period within which a person found guilty except for insanity may file a notice of appeal of the trial court's determination was extended from 30 days to 90 days after the order is entered in the register.

I. 2001 Legislation:

The timing of the transport by local law enforcement of a revoked PSRB client to Oregon State Hospital in Salem was changed from "immediate" to "as soon as practicable" when the revocation of conditional release is initiated by a designated authority other than the Board at night or on a weekend. This amendment brings the particular subsection into conformity with the timing statutorily mandated when the revocation is initiated by the Board.

I. Functioning of the Psychiatric Security Review Board

A. Membership of Board and Staff:

By statute, the membership of the PSRB consists of a psychiatrist and a psychologist experienced in the criminal justice system, an experienced parole and probation officer, an attorney experienced in criminal trial practice, and a member of the general public. The five Board positions are appointed by the governor and confirmed by the Senate for four-year terms. A chair is elected for a one-year term.

The Board's staff consists of an Executive Director, two administrative assistants and a secretary. The Executive Director oversees the day-to-day operations of the staff, including the monitoring of PSRB clients on conditional release, preparing orders resulting from Board hearings and affidavits and orders for revocation of conditional release. Preparation and presentation of the budget and legislative matters are performed by the director. She serves as agency spokesperson, maintaining a professional dialogue with persons in the mental health and corrections systems.

B. Board Hearings:

When the Board conducts a hearing, the person appearing before the Board has the right to be represented by an attorney. If the person cannot afford counsel, an attorney will be appointed. Currently, there is an attorney under contract with the State Court Administrator's Office to handle these cases as most persons under the Board's jurisdiction are indigent. After hearing testimony and reviewing exhibits, the Board must determine by a preponderance of the evidence whether or not the person continues to be affected by a mental disease or defect and whether the person presents a substantial danger to others. The Board also considers whether the person is appropriate for conditional release and whether an adequate and verified conditional release plan is available.

The Board meets in panels of three on a weekly basis. Prior to the hearing day, voluminous exhibit files are sent to panel members for review. There are generally eight to twelve cases set per hearing day, which take an average of 30 minutes per hearing. In addition, the Board considers an average of four administrative matters. A typical day will include several initial hearings of new patients, several patient requests for discharge or conditional release, a revocation hearing and perhaps an outpatient supervisor or hospital request for hearing. There are also mandatory two- and five-year hearings.

C. Commitment and Timing of Hearings:

If the record and testimony sustain findings that the person continues to be affected by a mental disease or defect and presents a substantial danger to others the person is committed to a state hospital designated by the Mental Health Division for care, custody and treatment. If a client can be adequately controlled and treated and there is a

placement available, the client can be conditionally released to the community. After the initial hearing, which must be held within 90 days of hospitalization, the person may petition for release every six months. Board staff then has sixty days to schedule the hearing. Hospital staff may petition for a hearing request for discharge or conditional release at any time.

D. **Conditional Release and Revocation**:

When release is appropriate and a verified plan is approved by the Board, the person is ordered released from the state hospital subject to the Board's specific conditions. These Board conditions include:

1. An appropriate housing situation;

2. Mental health treatment and supervision;

3. The designation of a person who agrees to report monthly to the Board concerning the released person's progress and who also agrees to notify the Board's director immediately of any violations of the release conditions; and

4. Any other special conditions such as taking of Antabuse, abstaining from alcohol and drugs, or submitting to random drug screen tests.

Once the Board staff receives information indicating a violation of the conditional release plan or change in mental status, the chairperson or a member of the Board reviews the record and recommends revocation. In the case of an extreme emergency, the executive director may execute a revocation, verifying it with a Board member within 72 hours. A revocation consists of a "warrant" which orders the person's release revoked and further orders any peace officer within the state to serve the warrant and transport the person back to the Forensic Psychiatric Programs at Oregon State Hospital. Pursuant to ORS 161.336(5), the Board then conducts a due process hearing within 20 days of the person's return to the custody of the Mental Health Division. At the hearing the Board makes findings on the appropriateness of the revocation and whether conditional release should be continued after hearing the testimony of psychiatric experts and considering all of the evidence on the record.

Typical reasons for a revocation include: discontinuance of medications, failure to come in for mental health appointments, experiencing an uncontrollable change in mental health status, use of nonprescribed drugs or alcohol.

E. **Appeals**:

When the person believes that the court erred in placing the person under the jurisdiction of the Board, the person may appeal from the court's order within 90 days of the court's entering of the judgment order. The court's judgment order is a "final" order for purposes of appeal.

A person under the jurisdiction of the Board may also petition the Court of Appeals for judicial review of the Board's findings within 60 days of the entering of the Board's order following a hearing.

F. **Cost**:

The Psychiatric Security Review Board is a State agency and the Legislature funds both the functioning of the Board and the funding of the mental health treatment and supervision of the patients in the community. The cost of the Oregon system involves a budget for the 2001-03 biennium of $738,229 for Board functioning, hearings and staff.

The 2001-03 biennium legislative allotment for community treatment and supervision of PSRB patients on conditional release is approximately $3.1 million.

G. **Statistics**:

The Board is required by statute to maintain extensive records on each patient. Currently the Board has approximately 580 clients; 238 individuals reside in the community on conditional release. Close to 85% of the Board's clients are male. Seventy-five percent of placements under the Board are for felonies; primarily assaults and burglaries.

V. Summary

The Psychiatric Security Review Board has been the focus of international attention and study. An NBC white paper on "Crime and Insanity" shown on television in April 1983 focused on Oregon as a model system. In addition, the American Psychiatric Association statement on the insanity defense in December 1983 recommends the model system presently in operation in the State of Oregon under the aegis of the Psychiatric Security Review Board. The APA was impressed that:

> *Confinement and release decisions for acquittals are made by an experienced body that is not naive about the nature of violent behavior committed by mental patients and that allows a quasi-criminal approach for managing such persons. Psychiatrists participate in the work of the Oregon Board, but they do not have primary responsibility. The Association believes that this is as it should be since*

the decision to confine and release persons who have done violence to society involves more than psychiatric considerations. The interest of society, the interest of the criminal justice system and the interest of those who have been or might be victimized by violence must also be addressed in confinement and release decisions.

A report of the National Commission on the Insanity Defense issued in March 1983 and entitled "Myths and Realities", sponsored by the National Mental Health Association, recommends the adoption of a special statute to address the disposition of the acquittees after a finding of not responsible by reason of insanity of a violent crime. In that report, the National Commission also discusses the Oregon code creating the Psychiatric Security Review Board.

In 1989 the National Alliance for the Mentally Ill set goals and priorities which included the passing of statutes which provide improved systems for insanity acquittees, citing the Oregon Psychiatric Security Review Board as a model for such a statute.

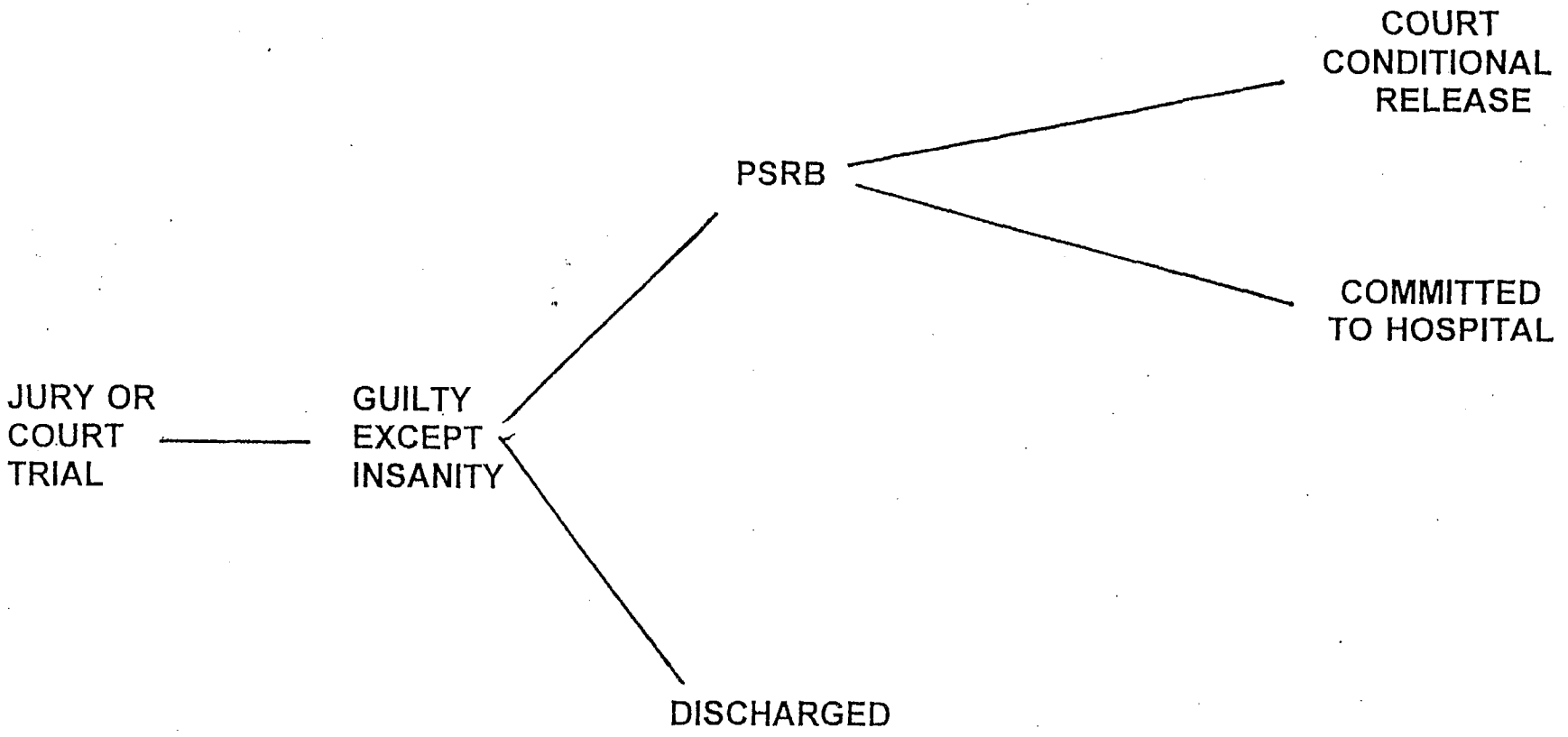
Most recently, the Psychiatric Security Review Board was named the APA's Hospital and Community Psychiatry's 1994 Gold Achievement Award winner. The award was given in recognition of the program's commitment to improved integration of mental health services within the criminal justice system and its responsibility to individual, community and societal values.

Oregon remains one of the states currently in the forefront of legal process in this area. Connecticut and Arizona have adopted the Oregon model. Other states, including Florida, Kentucky, Michigan, New Hampshire, and South Carolina have expressed an interest in this successful approach.

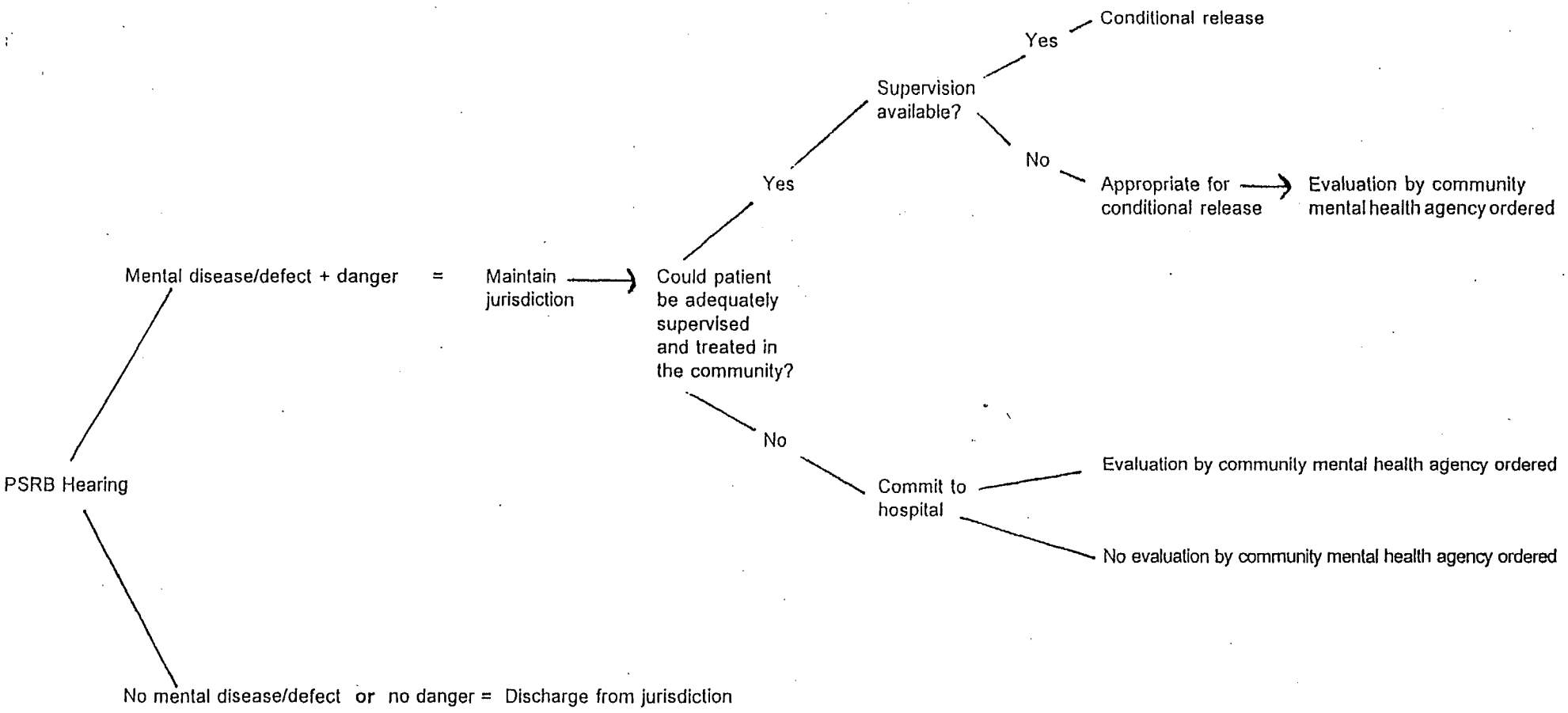
The insanity defense population will continue to be a part of our society. Oregon has chosen a unique approach by creating the Psychiatric Security Review Board which offers a multidisciplinary way of decision making. The Board's primary concern by statute is the protection of society. The system works well because of the ability of the Board to respond quickly to community emergencies and because the system balances the public's concern for safety, the treatment of persons in the community and the rights of the patients.

REVISED 10/01

COURT PROCESS - GUILTY EXCEPT INSANITY



PSRB HEARINGS PROCESS



Commitment to hospital - no further action until patient's next hearing
Evaluation - community mental health agency interviews patient to determine willingness to supervise
Appropriate for conditional release - could be adequately controlled and treated but need to put plan together
Conditional release - released to live in the community under close supervision

161.265 Use of physical force to prevent escape. A guard or other peace officer employed in a correctional facility, as that term is defined in ORS 162.135, is justified in using physical force including deadly physical force, when and to the extent that the guard or peace officer reasonably believes it necessary to prevent the escape of a prisoner from a correctional facility. [1971 c.743 §33]

161.270 Duress. (1) The commission of acts which would otherwise constitute an offense, other than murder, is not criminal if the actor engaged in the proscribed conduct because the actor was coerced to do so by the use or threatened use of unlawful physical force upon the actor or a third person, which force or threatened force was of such nature or degree to overcome earnest resistance.

(2) Duress is not a defense for one who intentionally or recklessly places oneself in a situation in which it is probable that one will be subjected to duress.

(3) It is not a defense that a spouse acted on the command of the other spouse, unless the spouse acted under such coercion as would establish a defense under subsection (1) of this section. [1971 c.743 §34; 1987 c.158 §22]

161.275 Entrapment. (1) The commission of acts which would otherwise constitute an offense is not criminal if the actor engaged in the proscribed conduct because the actor was induced to do so by a law enforcement official, or by a person acting in cooperation with a law enforcement official, for the purpose of obtaining evidence to be used against the actor in a criminal prosecution.

(2) As used in this section, "induced" means that the actor did not contemplate and would not otherwise have engaged in the proscribed conduct. Merely affording the actor an opportunity to commit an offense does not constitute entrapment. [1971 c.743 §35]

RESPONSIBILITY

161.290 Incapacity due to immaturity. (1) A person who is tried as an adult in a court of criminal jurisdiction is not criminally responsible for any conduct which occurred when the person was under 12 years of age.

(2) Incapacity due to immaturity, as defined in subsection (1) of this section, is a defense. [Formerly 161.380; 1995 c.422 §58]

161.295 Effect of mental disease or defect; guilty except for insanity. (1) A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.

(2) As used in chapter 743, Oregon Laws 1971, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor do they include any abnormality constituting solely a personality disorder. [1971 c.743 §36; 1983 c.800 §1]

Note: See note under 161.015.

161.300 Evidence of disease or defect admissible as to intent. Evidence that the actor suffered from a mental disease or defect is admissible whenever it is relevant to the issue of whether the actor did or did not have the intent which is an element of the crime. [1971 c.743 §37]

161.305 Disease or defect as affirmative defense. Mental disease or defect constituting insanity under ORS 161.295 is an affirmative defense. [1971 c.743 §38; 1983 c.800 §2]

161.309 Notice prerequisite to defense; content. (1) No evidence may be introduced by the defendant on the issue of insanity under ORS 161.295, unless the defendant gives notice of intent to do so in the manner provided in subsection (3) of this section.

(2) The defendant may not introduce in the case in chief expert testimony regarding partial responsibility under ORS 161.300 unless the defendant gives notice of intent to do so in the manner provided in subsection (3) of this section.

(3) A defendant who is required under subsection (1) or (2) of this section to give notice shall file a written notice of purpose at the time the defendant pleads not guilty. The defendant may file such notice at any time after the plea but before trial when just cause for failure to file the notice at the time of making the plea is made to appear to the satisfaction of the court. If the defendant fails to file notice, the defendant shall not be entitled to introduce evidence for the establishment of a defense under ORS 161.295 or 161.300 unless the court, in its discretion, permits such evidence to be introduced where just cause for failure to file the notice is made to appear. [1971 c.743 §§39,40,41; 1983 c.800 §3]

161.310 [Repealed by 1971 c.743 §432]

161.313 Jury instructions; insanity. When the issue of insanity under ORS 161.295 is submitted to be determined by a jury in the trial court, the court shall instruct the jury in accordance with ORS 161.327. [1983 c.800 §16]

161.315 Right of state to obtain mental examination of defendant; limitations. Upon filing of notice or the introduction of evidence by the defendant as provided in ORS 161.309 (3), the state shall have the

right to have at least one psychiatrist or licensed psychologist of its selection examine the defendant. The state shall file notice with the court of its intention to have the defendant examined. Upon filing of the notice, the court, in its discretion, may order the defendant committed to a state institution or any other suitable facility for observation and examination as it may designate for a period not to exceed 30 days. If the defendant objects to the examiner chosen by the state, the court for good cause shown may direct the state to select a different examiner. [1971 c.743 §42; 1977 c.380 §3]

161.319 Form of verdict on guilty except for insanity. When the defendant is found guilty except for insanity under ORS 161.295, the verdict and judgment shall so state. [1971 c.743 §43; 1977 c.380 §4; 1983 c.800 §4]

161.320 [Repealed by 1971 c.743 §432]

161.325 Entry of judgment of guilty except for insanity; order to include whether victim wants notice of hearings or release of defendant; blood or buccal testing upon judgment. (1) After entry of judgment of guilty except for insanity, the court shall, on the basis of the evidence given at the trial or at a separate hearing, if requested by either party, make an order as provided in ORS 161.327 or 161.329, whichever is appropriate.

(2) If the court makes an order as provided in ORS 161.327, it shall also:

(a) Determine on the record the offense of which the person otherwise would have been convicted; and

(b) Make specific findings on whether there is a victim of the crime for which the defendant has been found guilty except for insanity and, if so, whether the victim wishes to be notified, under ORS 161.326 (2), of any Psychiatric Security Review Board hearings concerning the defendant and of any conditional release, discharge or escape of the defendant.

(3) The court shall include any such findings in its order.

(4) Except under circumstances described in ORS 137.076 (4), whenever a defendant charged with any offense listed in ORS 137.076 (1) has been found guilty of that offense except for insanity, the court shall, in any order entered under ORS 161.327 or 161.329, direct the defendant to submit to the obtaining of a blood or buccal sample in the manner provided in ORS 137.076. [1971 c.743 §44; 1977 c.380 §5; 1979 c.885 §1; 1981 c.711 §1; 1983 c.800 §5; 1991 c.669 §8; 1999 c.97 §2]

161.326 Commission of crime by person under board jurisdiction; notice to victim. (1) Whenever a person already under the board's jurisdiction commits a new crime, the court or the board shall make the findings described in ORS 161.325 (2).

(2) If the trial court or the board determines that a victim desires notification as described in ORS 161.325 (2), the board shall make a reasonable effort to notify the victim of board hearings, conditional release, discharge or escape. [1981 c.711 §9]

Note: 161.326 and 161.387 were added to and made a part of ORS chapter 161 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

161.327 Order giving jurisdiction to Psychiatric Security Review Board; court to commit or conditionally release defendant; notice to board; appeal. (1) Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a felony, or of a misdemeanor during a criminal episode in the course of which the person caused physical injury or risk of physical injury to another, and if the court finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others requiring commitment to a state mental hospital designated by the Department of Human Services or conditional release, the court shall order the person placed under the jurisdiction of the Psychiatric Security Review Board for care and treatment. The period of jurisdiction of the board shall be equal to the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(2) The court shall determine whether the person should be committed to a state hospital designated by the Department of Human Services or conditionally released pending any hearing before the board as follows:

(a) If the court finds that the person presents a substantial danger to others and is not a proper subject for conditional release, the court shall order the person committed to a state hospital designated by the Department of Human Services for custody, care and treatment pending hearing before the board in accordance with ORS 161.341 to 161.351.

(b) If the court finds that the person presents a substantial danger to others but that the person can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the court may order the person conditionally released, subject to those supervisory orders of the court as are in the best interests of justice, the protection of society and the welfare of the person. The court shall designate a person or state,

county or local agency to supervise the person upon release, subject to those conditions as the court directs in the order for conditional release. Prior to the designation, the court shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the court. After receiving an order entered under this paragraph, the person or agency designated shall assume supervision of the person pursuant to the direction of the Psychiatric Security Review Board. The person or agency designated as supervisor shall be required to report in writing no less than once per month to the board concerning the supervised person's compliance with the conditions of release.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others.

(4) In determining whether a person should be conditionally released, the court may order evaluations, examinations and compliance as provided in ORS 161.336 (4) and 161.346 (2).

(5) In determining whether a person should be committed to a state hospital or conditionally released, the court shall have as its primary concern the protection of society.

(6) Upon placing a person on conditional release, the court shall notify the board in writing of the court's conditional release order, the supervisor appointed, and all other conditions of release, and the person shall be on conditional release pending hearing before the board in accordance with ORS 161.336 to 161.351. Upon compliance with this subsection and subsections (1) and (2) of this section, the court's jurisdiction over the person is terminated and the board assumes jurisdiction over the person.

(7) An order of the court under this section is a final order appealable by the person found guilty except for insanity in accordance with ORS 19.205 (4). Notwithstanding ORS 19.255, notice of an appeal under this section shall be served and filed within 90 days after the order appealed from is entered in the register. The person shall be entitled on appeal to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is indigent, suitable counsel shall be appointed in the manner provided in ORS 138.500 (1), and the compensation for counsel and costs and expenses of the person necessary to the appeal shall be determined, allowed and paid as provided in ORS 138.500.

(8) Upon placing a person under the jurisdiction of the board, the court shall notify the person of the right to appeal and the right to a hearing before the board in accordance with ORS 161.336 (7) and 161.341 (4).

[1979 c.867 §5; 1979 c.885 §2; 1981 c.711 §2; 1981 s.s. c.3 §129; 1983 c.800 §6; 1989 c.790 §48; 1995 c.208 §1]

Note: The amendments to 161.327 by section 88, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

161.327. (1) Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a felony, or of a misdemeanor during a criminal episode in the course of which the person caused physical injury or risk of physical injury to another, and if the court finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others requiring commitment to a state mental hospital designated by the Department of Human Services or conditional release, the court shall order the person placed under the jurisdiction of the Psychiatric Security Review Board for care and treatment. The period of jurisdiction of the board shall be equal to the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(2) The court shall determine whether the person should be committed to a state hospital designated by the Department of Human Services or conditionally released pending any hearing before the board as follows:

(a) If the court finds that the person presents a substantial danger to others and is not a proper subject for conditional release, the court shall order the person committed to a state hospital designated by the Department of Human Services for custody, care and treatment pending hearing before the board in accordance with ORS 161.341 to 161.351.

(b) If the court finds that the person presents a substantial danger to others but that the person can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the court may order the person conditionally released, subject to those supervisory orders of the court as are in the best interests of justice, the protection of society and the welfare of the person. The court shall designate a person or state, county or local agency to supervise the person upon release, subject to those conditions as the court directs in the order for conditional release. Prior to the designation, the court shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the court. After receiving an order entered under this paragraph, the person or agency designated shall assume supervision of the person pursuant to the direction of the Psychiatric Security Review Board. The person or agency designated as supervisor shall be required to report in writing no less than once per month to the board concerning the supervised person's compliance with the conditions of release.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others.

(4) In determining whether a person should be conditionally released, the court may order evaluations,

examinations and compliance as provided in ORS 161.336 (4) and 161.346 (2).

(5) In determining whether a person should be committed to a state hospital or conditionally released, the court shall have as its primary concern the protection of society.

(6) Upon placing a person on conditional release, the court shall notify the board in writing of the court's conditional release order, the supervisor appointed, and all other conditions of release, and the person shall be on conditional release pending hearing before the board in accordance with ORS 161.336 to 161.351. Upon compliance with this subsection and subsections (1) and (2) of this section, the court's jurisdiction over the person is terminated and the board assumes jurisdiction over the person.

(7) An order of the court under this section is a final order appealable by the person found guilty except for insanity in accordance with ORS 19.205 (4). Notwithstanding ORS 19.255, notice of an appeal under this section shall be served and filed within 90 days after the order appealed from is entered in the register. The person shall be entitled on appeal to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is financially eligible, suitable counsel shall be appointed in the manner provided in ORS 138.500 (1), and the compensation for counsel and costs and expenses of the person necessary to the appeal shall be determined and paid as provided in ORS 138.500.

(8) Upon placing a person under the jurisdiction of the board, the court shall notify the person of the right to appeal and the right to a hearing before the board in accordance with ORS 161.336 (7) and 161.341 (4).

Note: 161.327 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.328 Initiation of civil commitment proceedings. Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a misdemeanor during a criminal episode in the course of which the person did not cause physical injury or risk of physical injury to another, and if the court has probable cause to believe that the person is dangerous to self or others as a result of a mental disorder, the court may initiate civil commitment proceedings under ORS 426.070 to 426.130. [1981 c.711 §3; 1983 c.800 §7; 1987 c.903 §36; 1995 c.529 §1]

161.329 Order of discharge. Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others and is not in need of care, supervision or treatment, the court shall order the person discharged from custody. [1971 c.743 §45; 1977 c.380 §6; 1981 c.711 §4]

161.330 [Repealed by 1971 c.743 §432]

161.332 "Conditional release" defined. As used in ORS 161.315 to 161.351 and 161.385 to 161.395, "conditional release" includes, but is not limited to, the monitoring of mental and physical health treatment. [1977 c.380 §1; 1983 c.800 §8]

161.335 [1971 c.743 §46; 1973 c.137 §1; 1975 c.380 §1; repealed by 1977 c.380 §10 (161.336 enacted in lieu of 161.335)]

161.336 Conditional release by Psychiatric Security Review Board; supervision by board; termination or modification of conditional release; hearing. (1) If the board determines that the person presents a substantial danger to others but can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the board may order the person conditionally released, subject to those supervisory orders of the board as are in the best interests of justice, the protection of society and the welfare of the person. The board may designate any person or state, county or local agency the board considers capable of supervising the person upon release, subject to those conditions as the board directs in the order for conditional release. Prior to the designation, the board shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the board. After receiving an order entered under this section, the person or agency designated shall assume supervision of the person pursuant to the direction of the board.

(2) Conditions of release contained in orders entered under this section may be modified from time to time and conditional releases may be terminated by order of the board as provided in ORS 161.351.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others. The person may be continued on conditional release by the board as provided in this section.

(4)(a) As a condition of release, the board may require the person to report to any state or local mental health facility for evaluation. Whenever medical, psychiatric or psychological treatment is recommended, the board may order the person, as a condition of release, to cooperate with and accept the treatment from the facility.

(b) The facility to which the person has been referred for evaluation shall perform the evaluation and submit a written report

of its findings to the board. If the facility finds that treatment of the person is appropriate, it shall include its recommendations for treatment in the report to the board.

(c) Whenever treatment is provided by the facility, it shall furnish reports to the board on a regular basis concerning the progress of the person.

(d) Copies of all reports submitted to the board pursuant to this section shall be furnished to the person and the person's counsel. The confidentiality of these reports shall be determined pursuant to ORS 192.501 to 192.505.

(e) The facility shall comply with any other conditions of release prescribed by order of the board.

(5) If at any time while the person is under the jurisdiction of the board it appears to the board or its chairperson that the person has violated the terms of the conditional release or that the mental health of the individual has changed, the board or its chairperson may order the person returned to a state hospital designated by the Department of Human Services for evaluation or treatment. A written order of the board, or its chairperson on behalf of the board, is sufficient warrant for any law enforcement officer to take into custody such person and transport the person accordingly. A sheriff, municipal police officer, constable, parole or probation officer, prison official or other peace officer shall execute the order, and the person shall be returned as soon as practicable to the custody of the Department of Human Services. Within 20 days following the return of the person to the custody of the Department of Human Services, the board shall conduct a hearing. Notice of the time and place of the hearing shall be given to the person, the attorney representing the person and the Attorney General. The board may continue the person on conditional release or, if it finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others and cannot be adequately controlled if conditional release is continued, it may order the person committed to a state hospital designated by the Department of Human Services. The state must prove by a preponderance of the evidence the person's unfitness for conditional release. A person in custody pursuant to this subsection shall have the same rights as any person appearing before the board pursuant to ORS 161.346.

(6) The community mental health and developmental disabilities program director, the director of the facility providing treatment to a person on conditional release, any peace officer or any person responsible for the supervision of a person on conditional release may take a person on conditional release into custody or request that the person be taken into custody if there is reasonable cause to believe the person is a substantial danger to others because of mental disease or defect and that the person is in need of immediate care, custody or treatment. Any person taken into custody pursuant to this subsection shall be transported as soon as practicable to a state hospital designated by the Department of Human Services. A person taken into custody under this subsection shall have the same rights as any person appearing before the board pursuant to ORS 161.346.

(7)(a) Any person conditionally released under this section may apply to the board for discharge from or modification of an order of conditional release on the ground that the person is no longer affected by mental disease or defect or, if still so affected, no longer presents a substantial danger to others and no longer requires supervision, medication, care or treatment. Notice of the hearing on an application for discharge or modification of an order of conditional release shall be made to the Attorney General. The applicant, at the hearing pursuant to this subsection, must prove by a preponderance of the evidence the applicant's fitness for discharge or modification of the order of conditional release. Applications by the person for discharge or modification of conditional release shall not be filed more often than once every six months.

(b) Upon application by any person or agency responsible for supervision or treatment pursuant to an order of conditional release, the board shall conduct a hearing to determine if the conditions of release shall be continued, modified or terminated. The application shall be accompanied by a report setting forth the facts supporting the application.

(8) The total period of commitment and conditional release ordered pursuant to this section shall not exceed the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(9) The board shall maintain and keep current the medical, social and criminal history of all persons committed to its jurisdiction. The confidentiality of records maintained by the board shall be determined pursuant to ORS 192.501 to 192.505.

(10) In determining whether a person should be committed to a state hospital, conditionally released or discharged, the board shall have as its primary concern the protection of society. [1977 c.380 §11 (enacted in lieu

of 161.335); 1979 c.885 §3; 1981 c.711 §5; 1983 c.800 §9; 1987 c.140 §1; 1989 c.790 §49; 2001 c.326 §1]

161.340 [1971 c.743 §47; 1975 c.380 §2; repealed by 1977 c.380 §12 (161.341 enacted in lieu of 161.340)]

161.341 Order of commitment; application for discharge or conditional release; release plan. (1) If the board finds, upon its initial hearing, that the person presents a substantial danger to others and is not a proper subject for conditional release, the board shall order the person committed to, or retained in, a state hospital designated by the Department of Human Services for custody, care and treatment. The period of commitment ordered by the board shall not exceed the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(2) If at any time after the commitment of a person to a state hospital designated by the Department of Human Services under this section, the superintendent of the hospital is of the opinion that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others or that the person continues to be affected by mental disease or defect and continues to be a danger to others, but that the person can be controlled with proper care, medication, supervision and treatment if conditionally released, the superintendent shall apply to the board for an order of discharge or conditional release. The application shall be accompanied by a report setting forth the facts supporting the opinion of the superintendent. If the application is for conditional release, the application must also be accompanied by a verified conditional release plan. The board shall hold a hearing on the application within 60 days of its receipt. Not less than 20 days prior to the hearing before the board, copies of the report shall be sent to the Attorney General.

(3) The attorney representing the state may choose a psychiatrist or licensed psychologist to examine the person prior to the initial or any later decision by the board on discharge or conditional release. The results of the examination shall be in writing and filed with the board, and shall include, but need not be limited to, an opinion as to the mental condition of the person, whether the person presents a substantial danger to others and whether the person could be adequately controlled with treatment as a condition of release.

(4) Any person who has been committed to a state hospital designated by the Department of Human Services for custody, care and treatment or another person acting on the person's behalf may apply to the board for an order of discharge or conditional release upon the grounds:

(a) That the person is no longer affected by mental disease or defect;

(b) If so affected, that the person no longer presents a substantial danger to others; or

(c) That the person continues to be affected by a mental disease or defect and would continue to be a danger to others without treatment, but that the person can be adequately controlled and given proper care and treatment if placed on conditional release.

(5) When application is made under subsection (4) of this section, the board shall require a report from the superintendent of the hospital which shall be prepared and transmitted as provided in subsection (2) of this section. The applicant must prove by a preponderance of the evidence the applicant's fitness for discharge or conditional release under the standards of subsection (4) of this section, unless more than two years has passed since the state had the burden of proof on that issue, in which case the state shall have the burden of proving by a preponderance of the evidence the applicant's lack of fitness for discharge or conditional release. Applications for discharge or conditional release under subsection (4) of this section shall not be filed more often than once every six months commencing with the date of the initial board hearing.

(6) The board is not required to hold a hearing on a first application under subsection (4) of this section any sooner than 90 days after the initial hearing. However, hearings resulting from any subsequent requests shall be held within 60 days of the filing of the application.

(7)(a) In no case shall any person committed by the court under ORS 161.327 to a state hospital designated by the Department of Human Services be held in the hospital for more than 90 days from the date of the court's commitment order without an initial hearing before the board to determine whether the person should be conditionally released or discharged.

(b) In no case shall a person be held pursuant to this section for a period of time exceeding two years without a hearing before the board to determine whether the person should be conditionally released or discharged. [1977 c.380 §13 (enacted in lieu of 161.340); 1979 c.885 §4; 1981 c.711 §6; 1983 c.800 §10; 1985 c.192 §3; 1989 c.790 §50; 1991 c.244 §1]

161.345 [1971 c.743 §48; repealed by 1977 c.380 §14 (161.346 enacted in lieu of 161.345)]

161.346 Hearings on discharge, conditional release, commitment or modification; psychiatric reports; notice of hearing. (1) The board shall conduct hearings upon any application for discharge, conditional release, commitment or modification filed pursuant to ORS 161.336, 161.341 or 161.351 and as otherwise required by ORS 161.336 to 161.351 and shall make findings on the issues before it which may include:

(a) If the board finds that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others, the board shall order the person discharged from commitment or from conditional release.

(b) If the board finds that the person is still affected by a mental disease or defect and is a substantial danger to others, but can be controlled adequately if conditionally released with treatment as a condition of release, the board shall order the person conditionally released as provided in ORS 161.336.

(c) If the board finds that the person has not recovered from the mental disease or defect and is a substantial danger to others and cannot adequately be controlled if conditionally released on supervision, the board shall order the person committed to, or retained in, a state hospital designated by the Department of Human Services for care, custody and treatment.

(2) At any time, the board may appoint a psychiatrist or licensed psychologist to examine the person and to submit a report to the board. Reports filed with the board pursuant to the examination shall include, but need not be limited to, an opinion as to the mental condition of the person and whether the person presents a substantial danger to others, and whether the person could be adequately controlled with treatment as a condition of release. To facilitate the examination of the person, the board may order the person placed in the temporary custody of any state hospital or other suitable facility.

(3) The board may make the determination regarding discharge or conditional release based upon the written reports submitted pursuant to this section. If any member of the board desires further information from the examining psychiatrist or licensed psychologist who submitted the report, these persons shall be summoned by the board to give testimony. The board shall consider all evidence available to it which is material, relevant and reliable regarding the issues before the board. Such evidence may include but is not limited to the record of trial, the information supplied by the attorney representing the state or by any other interested party, including the person, and information concerning the person's mental condition and the entire psychiatric and criminal history of the person. All evidence of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs shall be admissible at hearings. Testimony shall be taken upon oath or affirmation of the witness from whom received. The officer presiding at the hearing shall administer oaths or affirmations to witnesses.

(4) The board shall furnish to the person about whom the hearing is being conducted, the attorney representing the person, the Attorney General, the district attorney and the court or department of the county from which the person was committed written notice of any hearing pending under this section within a reasonable time prior to the hearing. The notice shall include:

(a) The time, place and location of the hearing.

(b) The nature of the hearing and the specific action for which a hearing has been requested, the issues to be considered at the hearing and a reference to the particular sections of the statutes and rules involved.

(c) A statement of the authority and jurisdiction under which the hearing is to be held.

(d) A statement of all rights under subsection (6) of this section.

(5) Prior to the commencement of a hearing, the board or presiding officer shall inform each party as provided in ORS 183.413 (2).

(6) At the hearing, the person about whom the hearing is being held shall have the right:

(a) To appear at all proceedings held pursuant to this section, except board deliberations.

(b) To cross-examine all witnesses appearing to testify at the hearing.

(c) To subpoena witnesses and documents as provided in ORS 161.395.

(d) To be represented by suitable legal counsel possessing skills and experience commensurate with the nature and complexity of the case, to consult with counsel prior to the hearing and, if indigent, to have suitable counsel provided without cost.

(e) To examine all information, documents and reports which the board considers. If then available to the board, the information, documents and reports shall be disclosed to the person so as to allow examination prior to the hearing.

(7) A record shall be kept of all hearings before the board, except board deliberations.

(8) Upon request of any party before the board, or on its own motion, the board may continue a hearing for a reasonable period not to exceed 60 days to obtain additional information or testimony or for other good cause shown.

(9) Within 15 days following the conclusion of the hearing, the board shall provide to the person, the attorney representing the person, the Attorney General or other attorney representing the state, if any, written notice of the board's decision.

(10) The burden of proof on all issues at hearings of the board shall be by a preponderance of the evidence.

(11) If the board determines that the person about whom the hearing is being held is indigent, the board shall appoint suitable counsel to represent the person. Counsel so appointed shall be an attorney who satisfies the standards of eligibility established by the State Court Administrator under ORS 151.430. The State Court Administrator shall determine and allow fair compensation for counsel appointed under this subsection and the reasonable expenses of the person in respect to the hearing. Compensation payable to appointed counsel shall not be less than $30 an hour. The compensation and expenses so allowed shall be paid by the administrator from funds available for the purpose. If appointed counsel is under contract to provide services for the proceeding under ORS 151.460, compensation shall be as provided by the contract.

(12) The Attorney General may represent the state at contested hearings before the board unless the district attorney of the county from which the person was committed elects to represent the state. The district attorney of the county from which the person was committed shall cooperate with the Attorney General in securing the material necessary for presenting a contested hearing before the board. If the district attorney elects to represent the state, the district attorney shall give timely written notice of such election to the Attorney General, the board and the attorney representing the person. [1977 c.380 §15 (enacted in lieu of 161.345); 1979 c.867 §6; 1979 c.885 §5; 1981 c.711 §7; 1981 s.s c.3 §130; 1983 c.430 §1; 1985 c.502 §23; 1987 c.803 §19; 1991 c.827 §3]

Note: The amendments to 161.346 by section 40, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

161.346. (1) The Psychiatric Security Review Board shall conduct hearings upon any application for discharge, conditional release, commitment or modification filed pursuant to ORS 161.336, 161.341 or 161.351 and as otherwise required by ORS 161.336 to 161.351 and shall make findings on the issues before it which may include:

(a) If the board finds that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others, the board shall order the person discharged from commitment or from conditional release.

(b) If the board finds that the person is still affected by a mental disease or defect and is a substantial danger to others, but can be controlled adequately if conditionally released with treatment as a condition of release, the board shall order the person conditionally released as provided in ORS 161.336.

(c) If the board finds that the person has not recovered from the mental disease or defect and is a substantial danger to others and cannot adequately be controlled if conditionally released on supervision, the board shall order the person committed to, or retained in, a state hospital designated by the Department of Human Services for care, custody and treatment.

(2) At any time, the board may appoint a psychiatrist or licensed psychologist to examine the person and to submit a report to the board. Reports filed with the board pursuant to the examination shall include, but need not be limited to; an opinion as to the mental condition of the person and whether the person presents a substantial danger to others, and whether the person could be adequately controlled with treatment as a condition of release. To facilitate the examination of the person, the board may order the person placed in the temporary custody of any state hospital or other suitable facility.

(3) The board may make the determination regarding discharge or conditional release based upon the written reports submitted pursuant to this section. If any member of the board desires further information from the examining psychiatrist or licensed psychologist who submitted the report, these persons shall be summoned by the board to give testimony. The board shall consider all evidence available to it which is material, relevant and reliable regarding the issues before the board. Such evidence may include but is not limited to the record of trial, the information supplied by the attorney representing the state or by any other interested party, including the person, and information concerning the person's mental condition and the entire psychiatric and criminal history of the person. All evidence of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs shall be admissible at hearings. Testimony shall be taken upon oath or affirmation of the witness from whom received. The officer presiding at the hearing shall administer oaths or affirmations to witnesses.

(4) The board shall furnish to the person about whom the hearing is being conducted, the attorney representing the person, the Attorney General, the district attorney and the court or department of the county from which the person was committed written notice of any hearing pending under this section within a reasonable time prior to the hearing. The notice shall include:

(a) The time, place and location of the hearing.

(b) The nature of the hearing and the specific action for which a hearing has been requested, the issues to be considered at the hearing and a reference to the particular sections of the statutes and rules involved.

(c) A statement of the authority and jurisdiction under which the hearing is to be held.

(d) A statement of all rights under subsection (6) of this section.

(5) Prior to the commencement of a hearing, the board or presiding officer shall inform each party as provided in ORS 183.413 (2).

(6) At the hearing, the person about whom the hearing is being held shall have the right:

(a) To appear at all proceedings held pursuant to this section, except board deliberations.

(b) To cross-examine all witnesses appearing to testify at the hearing.

(c) To subpoena witnesses and documents as provided in ORS 161.395.

(d) To be represented by suitable legal counsel possessing skills and experience commensurate with the nature and complexity of the case, to consult with counsel prior to the hearing and, if financially eligible, to have suitable counsel appointed at state expense.

(e) To examine all information, documents and reports which the board considers. If then available to the board, the information, documents and reports shall be disclosed to the person so as to allow examination prior to the hearing.

(7) A record shall be kept of all hearings before the board, except board deliberations.

(8) Upon request of any party before the board, or on its own motion, the board may continue a hearing for a reasonable period not to exceed 60 days to obtain additional information or testimony or for other good cause shown.

(9) Within 15 days following the conclusion of the hearing, the board shall provide to the person, the attorney representing the person, the Attorney General or other attorney representing the state, if any, written notice of the board's decision.

(10) The burden of proof on all issues at hearings of the board shall be by a preponderance of the evidence.

(11) If the board determines that the person about whom the hearing is being held is financially eligible, the board shall appoint suitable counsel to represent the person. Counsel so appointed shall be an attorney who satisfies the professional qualification standards established by the Public Defense Services Commission under ORS 151.216. The public defense services executive director shall determine and allow fair compensation for counsel appointed under this subsection and the reasonable expenses of the person in respect to the hearing. Compensation payable to appointed counsel shall not be less than the applicable compensation level established under ORS 151.216. The compensation and expenses so allowed shall be paid by the public defense services executive director from funds available for the purpose.

(12) The Attorney General may represent the state at contested hearings before the board unless the district attorney of the county from which the person was committed elects to represent the state. The district attorney of the county from which the person was committed shall cooperate with the Attorney General in securing the material necessary for presenting a contested hearing before the board. If the district attorney elects to represent the state, the district attorney shall give timely written notice of such election to the Attorney General, the board and the attorney representing the person.

161.350 [1971 c.743 §49; 1975 c.380 §3; repealed by 1977 c.380 §16 (161.351 enacted in lieu of 161.350)]

161.351 Discharge of person under jurisdiction of board; periodic review of status. (1) Any person placed under the jurisdiction of the Psychiatric Security Review Board pursuant to ORS 161.336 or 161.341 shall be discharged at such time as the board, upon a hearing, shall find by a preponderance of the evidence that the person is no longer affected by mental disease or defect or, if so affected, no longer presents a substantial danger to others which requires regular medical care, medication, supervision or treatment.

(2) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect. A person whose mental disease or defect may, with reasonable medical probability, occasionally become active and when it becomes active will render the person a danger to others, shall not be discharged. The person shall continue under such supervision and treatment as the board deems necessary to protect the person and others.

(3) Any person who has been placed under the jurisdiction of the board and who has spent five years on conditional release shall be brought before the board for hearing within 30 days of the expiration of the five-year period. The board shall review the person's status and determine whether the person should be discharged from the jurisdiction of the board. [1977 c.380 §17 (enacted in lieu of 161.350); 1981 c.711 §13; 1985 c.192 §4; 1989 c.49 §1]

161.360 Mental disease or defect excluding fitness to proceed. (1) If, before or during the trial in any criminal case, the court has reason to doubt the defendant's fitness to proceed by reason of incapacity, the court may order an examination in the manner provided in ORS 161.365.

(2) A defendant may be found incapacitated if, as a result of mental disease or defect, the defendant is unable:

(a) To understand the nature of the proceedings against the defendant; or

(b) To assist and cooperate with the counsel of the defendant; or

(c) To participate in the defense of the defendant. [1971 c.743 §50; 1993 c.238 §1]

161.365 Procedure for determining issue of fitness to proceed. (1) Whenever the court has reason to doubt the defendant's fitness to proceed by reason of incapacity as defined in ORS 161.360, the court may call to its assistance in reaching its decision any witness and may appoint a psychiatrist or psychologist to examine the defendant and advise the court.

(2) If the court determines the assistance of a psychiatrist or psychologist would be helpful, the court may order the defendant to be committed to a state mental hospital designated by the Department of Human Services for the purpose of an examination for a period not exceeding 30 days. The report of each examination shall include, but is not necessarily limited to, the following:

(a) A description of the nature of the examination;

(b) A statement of the mental condition of the defendant; and

(c) If the defendant suffers from a mental disease or defect, an opinion as to whether the defendant is incapacitated within the definition set out in ORS 161.360.

(3) Except where the defendant and the court both request to the contrary, the report shall not contain any findings or conclusions as to whether the defendant as a result of mental disease or defect was subject to the provisions of ORS 161.295 or 161.300 at the time of the criminal act charged.

(4) If the examination by the psychiatrist or psychologist cannot be conducted by reason of the unwillingness of the defendant to participate therein, the report shall so state and shall include, if possible, an opinion as to whether such unwillingness of the defendant was the result of mental disease or defect affecting capacity to proceed.

(5) The report of the examination shall be filed in triplicate with the clerk of the court, who shall cause copies to be delivered to the district attorney and to counsel for defendant.

(6) When upon motion of the court or indigent defendant, the court has ordered a psychiatric or psychological examination of the indigent defendant, a justice court shall order the county to pay, and a circuit court shall order the State Court Administrator to pay from funds available for the purpose:

(a) A reasonable fee if the examination of the defendant is conducted by a psychiatrist or psychologist in private practice; and

(b) All costs including transportation of the defendant if the examination is conducted by a psychiatrist or psychologist in the employ of the Department of Human Services or a community mental health and developmental disabilities program established under ORS 430.610 to 430.670.

(7) When such an examination is ordered at the request or with the acquiescence of a defendant who is determined not to be indigent, the examination shall be performed at the defendant's expense. When such an examination is ordered at the request of the prosecution, the county shall pay for the expense of the examination. [1971 c.743 §51; 1975 c.380 §4; 1981 s.s. c.3 §131; 1983 c.800 §11; 1987 c.803 §18; 1993 c.238 §2]

Note: The amendments to 161.365 by section 90, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

161.365. (1) Whenever the court has reason to doubt the defendant's fitness to proceed by reason of incapacity as defined in ORS 161.360, the court may call to its assistance in reaching its decision any witness and may appoint a psychiatrist or psychologist to examine the defendant and advise the court.

(2) If the court determines the assistance of a psychiatrist or psychologist would be helpful, the court may order the defendant to be committed to a state mental hospital designated by the Department of Human Services for the purpose of an examination for a period not exceeding 30 days. The report of each examination shall include, but is not necessarily limited to, the following:

(a) A description of the nature of the examination;

(b) A statement of the mental condition of the defendant; and

(c) If the defendant suffers from a mental disease or defect, an opinion as to whether the defendant is incapacitated within the definition set out in ORS 161.360.

(3) Except where the defendant and the court both request to the contrary, the report shall not contain any findings or conclusions as to whether the defendant as a result of mental disease or defect was subject to the provisions of ORS 161.295 or 161.300 at the time of the criminal act charged.

(4) If the examination by the psychiatrist or psychologist cannot be conducted by reason of the unwillingness of the defendant to participate therein, the report shall so state and shall include, if possible, an opinion as to whether such unwillingness of the defendant was the result of mental disease or defect affecting capacity to proceed.

(5) The report of the examination shall be filed in triplicate with the clerk of the court, who shall cause copies to be delivered to the district attorney and to counsel for defendant.

(6) When upon motion of the court or a financially eligible defendant, the court has ordered a psychiatric or psychological examination of the defendant, a county or justice court shall order the county to pay, and a circuit court shall order the public defense services executive director to pay from funds available for the purpose:

(a) A reasonable fee if the examination of the defendant is conducted by a psychiatrist or psychologist in private practice; and

(b) All costs including transportation of the defendant if the examination is conducted by a psychiatrist or psychologist in the employ of the Department of Human Services or a community mental health and developmental disabilities program established under ORS 430.610 to 430.670.

(7) When such an examination is ordered at the request or with the acquiescence of a defendant who is determined not to be financially eligible, the examination shall be performed at the defendant's expense. When such an examination is ordered at the request of the prosecution, the county shall pay for the expense of the examination.

161.370 Determination of fitness; effect of finding of unfitness; proceedings if fitness regained; pretrial objections by defense counsel. (1) When the defendant's fitness to proceed is drawn in question, the issue shall be determined by the court. If neither the prosecuting attorney nor counsel for the defendant contests the finding of the report filed by a psychiatrist or psychologist under ORS 161.365, the court may make the determination on the basis of such report. If the finding is contested, the court shall hold a hearing on the issue. If the report is received in evidence upon such hearing, the

party who contests the finding thereof shall have the right to summon and to cross-examine any psychiatrist or psychologist who submitted the report and to offer evidence upon the issue. Other evidence regarding the defendant's fitness to proceed may be introduced by either party.

(2) If the court determines that the defendant lacks fitness to proceed, the proceeding against the defendant shall be suspended, except as provided in subsection (12) of this section, and the court shall commit the defendant to the custody of the superintendent of a state mental hospital designated by the Department of Human Services or shall release the defendant on supervision for so long as such unfitness shall endure. The court may release the defendant on supervision if it determines that care other than commitment for incapacity to stand trial would better serve the defendant and the community. It may place conditions which it deems appropriate on the release, including the requirement that the defendant regularly report to the Department of Human Services or a community mental health and developmental disabilities program for examination to determine if the defendant has regained capacity to stand trial. When the court, on its own motion or upon the application of the superintendent of the hospital in which the defendant is committed, a person examining the defendant as a condition of release on supervision, or either party, determines, after a hearing, if a hearing is requested, that the defendant has regained fitness to proceed, the proceeding shall be resumed. If, however, the court is of the view that so much time has elapsed since the commitment or release of the defendant on supervision that it would be unjust to resume the criminal proceeding, the court on motion of either party may dismiss the charge and may order the defendant to be discharged or cause a proceeding to be commenced forthwith under ORS 426.070 to 426.170 or 427.235 to 427.290.

(3) The superintendent shall cause the defendant to be evaluated within 60 days from the defendant's delivery into the superintendent's custody, for the purpose of determining whether there is a substantial probability that, in the foreseeable future, the defendant will have the capacity to stand trial.

(4) In addition, the superintendent shall:

(a) Immediately notify the committing court if the defendant, at any time, gains or regains the capacity to stand trial or will never have the capacity to stand trial.

(b) Within 90 days of the defendant's delivery into the superintendent's custody, notify the committing court that:

(A) The defendant has the present capacity to stand trial;

(B) There is no substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial; or

(C) There is a substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial. If such a probability exists, the superintendent shall give the court an estimate of the time in which the defendant, with appropriate treatment, is expected to gain or regain capacity.

(5) If the superintendent determines that there is a substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial, unless the court otherwise orders, the defendant shall remain in the superintendent's custody where the defendant shall receive treatment designed for the purpose of enabling the defendant to gain or regain capacity. In keeping with the notice requirement under subsection (4)(b) of this section, the superintendent shall, for the duration of the defendant's period of commitment, submit a progress report to the committing court, concerning the defendant's capacity or incapacity, at least once every 180 days as measured from the date of the defendant's delivery into the superintendent's custody.

(6) A defendant who remains committed under subsection (5) of this section shall be discharged within a period of time that is reasonable for making a determination concerning whether or not, and when, the defendant may gain or regain capacity. However, regardless of the number of charges with which the defendant is accused, in no event shall the defendant be committed for longer than whichever of the following, measured from the defendant's initial custody date, is shorter:

(a) Three years; or

(b) A period of time equal to the maximum sentence the court could have imposed if the defendant had been convicted.

(7) The superintendent shall notify the committing court of the defendant's impending discharge 30 days before the date on which the superintendent is required to discharge the defendant under subsection (6) of this section.

(8) When the committing court receives a notice from the superintendent under either subsection (4) or (7) of this section concerning the defendant's progress or lack thereof, the committing court shall determine after a hearing, if a hearing is requested, whether the defendant presently has the capacity to stand trial.

(9) If under subsection (8) of this section the court determines that the defendant lacks the capacity to stand trial, the court shall further determine whether there is a substantial probability that the defendant, in the foreseeable future, will gain or regain the capacity to stand trial and whether the defendant is entitled to discharge under subsection (6) of this section. If the court determines that there is no substantial probability that the defendant, in the foreseeable future, will gain or regain the capacity to stand trial or that the defendant is entitled to discharge under subsection (6) of this section, the court shall dismiss, without prejudice, all charges against the defendant and:

(a) Order that the defendant be discharged; or

(b) Initiate commitment proceedings under ORS 426.070 or 427.235 to 427.290.

(10) All notices required under this section shall be filed with the clerk of the court and delivered to both the district attorney and the counsel for the defendant.

(11) If the defendant regains fitness to proceed, the term of any sentence received by the defendant for conviction of the crime charged shall be reduced by the amount of time the defendant was committed under this section to the custody of a state mental hospital designated by the Department of Human Services.

(12) The fact that the defendant is unfit to proceed does not preclude any objection through counsel and without the personal participation of the defendant on the grounds that the indictment is insufficient, that the statute of limitations has run, that double jeopardy principles apply or upon any other ground at the discretion of the court which the court deems susceptible of fair determination prior to trial.

(13) As used in this section, "superintendent" means the superintendent of the state mental hospital of the Department of Human Services to which the defendant has been committed. [1971 c.743 §52; 1975 c.380 §5; 1993 c.238 §3; 1999 c.931 §§1,2]

161.375 Escape of person placed at Oregon State Hospital; authority of superintendent to order arrest. (1) When a patient, who has been placed at the Oregon State Hospital for evaluation, care, custody and treatment under the jurisdiction of the Psychiatric Security Review Board or by court order under ORS 161.315, 161.365 or 161.370, has escaped or is absent without authorization from the Oregon State Hospital or from the custody of any person in whose charge the superintendent has placed the patient, the superintendent may order the arrest and detention of the patient.

(2) The superintendent may issue an order under this section based upon a reasonable belief that grounds exist for issuing the order. When reasonable, the superintendent shall investigate to ascertain whether such grounds exist.

(3) Any order issued by the superintendent as authorized by this section constitutes full authority for the arrest and detention of the patient and all laws applicable to warrant or arrest apply to the order. An order issued by the superintendent under this section expires 72 hours after being signed by the superintendent.

(4) As used in this section, "superintendent" means the superintendent of the Oregon State Hospital or the superintendent's authorized representative. [1997 c.423 §1]

Note: 161.375 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.380 [1971 c.743 §53; renumbered 161.290]

161.385 Psychiatric Security Review Board; composition, term, qualifications, compensation, appointment, confirmation and meetings; judicial review of orders. (1) There is hereby created a Psychiatric Security Review Board consisting of five members appointed by the Governor and subject to confirmation by the Senate under section 4, Article III of the Oregon Constitution.

(2) The membership of the board shall not include any district attorney, deputy district attorney or public defender, but, the membership shall be composed of:

(a) A psychiatrist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Department of Human Services or a community mental health and developmental disabilities program;

(b) A licensed psychologist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Department of Human Services or a community mental health and developmental disabilities program;

(c) A member with substantial experience in the processes of parole and probation;

(d) A member of the general public; and

(e) A lawyer with substantial experience in criminal trial practice.

(3) The term of office of each member is four years. The Governor at any time may remove any member for inefficiency, neglect of duty or malfeasance in office. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there

is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) A member of the board not otherwise employed full time by the state, shall be paid on a per diem basis an amount equal to $212, adjusted according to the executive pay plan for the biennium, for each day during which the member is engaged in the performance of official duties, including necessary travel time. In addition, subject to ORS 292.220 to 292.250 regulating travel and other expenses of state officers and employees, the member shall be reimbursed for actual and necessary travel and other expenses incurred in the performance of official duties.

(5) Subject to any applicable provision of the State Personnel Relations Law, the board may hire employees to aid it in performing its duties.

(6)(a) The board shall select one of its members as chairperson to serve for a one-year term with such duties and powers as the board determines.

(b) A majority of the voting members of the board constitutes a quorum for the transaction of business.

(7) The board shall meet at least twice every month, unless the chairperson determines that there is not sufficient business before the board to warrant a meeting at the scheduled time. The board shall also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(8)(a) When a person over whom the board exercises its jurisdiction is adversely affected or aggrieved by a final order of the board, the person is entitled to judicial review of the final order. The person shall be entitled on judicial review to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is indigent, suitable counsel shall be appointed by the reviewing court in the manner provided in ORS 138.500 (1). If the person is indigent, the reviewing court shall determine and allow, as provided in ORS 138.500, the cost of briefs, any other expenses of the person necessary to the review and compensation for counsel appointed for the person. The costs, expenses and compensation so allowed shall be paid as provided in ORS 138.500.

(b) The order and the proceedings underlying the order are subject to review by the Court of Appeals upon petition to that court filed within 60 days of the order for which review is sought. The board shall submit to the court the record of the proceeding or, if the person agrees, a shortened record. The record may include a certified true copy of a tape recording of the proceedings at a hearing in accordance with ORS 161.346. A copy of the record transmitted shall be delivered to the person by the board.

(c) The court may affirm, reverse or remand the order on the same basis as provided in ORS 183.482 (8).

(d) The filing of the petition shall not stay the board's order, but the board or the Court of Appeals may order a stay upon application on such terms as are deemed proper. [1977 c.380 §8; 1979 c.867 §7; 1979 c.885 §6; 1981 c.711 §15; 1981 s.s. c.3 §132; 1983 c.740 §26; 1983 c.800 §12; 1987 c.133 §1]

Note: The amendments to 161.385 by section 70, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

161.385. (1) There is hereby created a Psychiatric Security Review Board consisting of five members appointed by the Governor and subject to confirmation by the Senate under section 4, Article III of the Oregon Constitution.

(2) The membership of the board shall not include any district attorney, deputy district attorney or public defender, but the membership shall be composed of:

(a) A psychiatrist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Department of Human Services or a community mental health and developmental disabilities program;

(b) A licensed psychologist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Department of Human Services or a community mental health and developmental disabilities program;

(c) A member with substantial experience in the processes of parole and probation;

(d) A member of the general public; and

(e) A lawyer with substantial experience in criminal trial practice.

(3) The term of office of each member is four years. The Governor at any time may remove any member for inefficiency, neglect of duty or malfeasance in office. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) A member of the board not otherwise employed full time by the state, shall be paid on a per diem basis an amount equal to $212, adjusted according to the executive pay plan for the biennium, for each day during which the member is engaged in the performance of official duties, including necessary travel time. In addition, subject to ORS 292.220 to 292.250 regulating travel and other expenses of state officers and employees, the member shall be reimbursed for actual and necessary travel and other expenses incurred in the performance of official duties.

(5) Subject to any applicable provision of the State Personnel Relations Law, the board may hire employees to aid it in performing its duties.

(6)(a) The board shall select one of its members as chairperson to serve for a one-year term with such duties and powers as the board determines.

(b) A majority of the voting members of the board constitutes a quorum for the transaction of business.

(7) The board shall meet at least twice every month, unless the chairperson determines that there is not sufficient business before the board to warrant a meeting at the scheduled time. The board shall also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(8)(a) When a person over whom the board exercises its jurisdiction is adversely affected or aggrieved by a final order of the board, the person is entitled to judicial review of the final order. The person is entitled on judicial review to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is financially eligible, suitable counsel shall be appointed by the reviewing court in the manner provided in ORS 138.500 (1). If the person is financially eligible, the public defense services executive director shall determine and pay, as provided in ORS 138.500, the cost of briefs, any other expenses of the person necessary to the review and compensation for counsel appointed for the person. The costs, expenses and compensation so allowed shall be paid as provided in ORS 138.500.

(b) The order and the proceedings underlying the order are subject to review by the Court of Appeals upon petition to that court filed within 60 days of the order for which review is sought. The board shall submit to the court the record of the proceeding or, if the person agrees, a shortened record. The record may include a certified true copy of a tape recording of the proceedings at a hearing in accordance with ORS 161.346. A copy of the record transmitted shall be delivered to the person by the board.

(c) The court may affirm, reverse or remand the order on the same basis as provided in ORS 183.482 (8).

(d) The filing of the petition shall not stay the board's order, but the board or the Court of Appeals may order a stay upon application on such terms as are deemed proper.

161.387 Board to implement policies; rulemaking; meetings not deliberative under public meeting requirements. (1) The Psychiatric Security Review Board, by rule pursuant to ORS 183.325 to 183.410 and not inconsistent with law, may implement its policies and set out its procedure and practice requirements and may promulgate such interpretive rules as the board deems necessary or appropriate to carry out its statutory responsibilities.

(2) Administrative meetings of the board and the evidentiary phase of board hearings are not deliberations for the purposes of ORS 192.690. [1981 c.711 §§10,11]

Note: See note under 161.326.

161.390 Rules for assignment of persons to state mental hospitals; release plan prepared by Department of Human Services. (1) The Department of Human Services shall promulgate rules for the assignment of persons to state mental hospitals under ORS 161.341, 161.365 and 161.370 and for establishing standards for evaluation and treatment of persons committed to a state hospital designated by the department or ordered to a community mental health and developmental disabilities program under ORS 161.315 to 161.351, 192.690 and 428.210.

(2) Whenever the Psychiatric Security Review Board requires the preparation of a predischarge or preconditional release plan before a hearing or as a condition of granting discharge or conditional release for a person committed under ORS 161.327 or 161.341 to a state hospital for custody, care and treatment, the Department of Human Services is responsible for and shall prepare the plan.

(3) In carrying out a conditional release plan prepared under subsection (2) of this section, the Department of Human Services may contract with a community mental health and developmental disabilities program, other public agency or private corporation or an individual to provide supervision and treatment for the conditionally released person. [1975 c.380 §7; 1977 c.380 §18; 1981 c.711 §14; 1993 c.680 §18]

161.395 Subpoena power of board. (1) Upon request of any party to a hearing before the board, the board or its designated representatives shall issue, or the board on its own motion may issue, subpoenas requiring the attendance and testimony of witnesses.

(2) Upon request of any party to the hearing before the board and upon a proper showing of the general relevance and reasonable scope of the documentary or physical evidence sought, the board or its designated representative shall issue, or the board on its own motion may issue, subpoenas duces tecum.

(3) Witnesses appearing under subpoenas, other than the parties or state officers or employees, shall receive fees and mileage as prescribed by law for witnesses in ORS 44.415 (2). If the board or its designated representative certifies that the testimony of a witness was relevant and material, any person who has paid fees and mileage to that witness shall be reimbursed by the board.

(4) If any person fails to comply with a subpoena issued under subsections (1) or (2) of this section or any party or witness refuses to testify regarding any matter on which the party or witness may be lawfully interrogated, the judge of the circuit court of any county, on the application of the board or its designated representative or of the party requesting the issuance of the subpoena, shall compel obedience by proceedings for contempt as in the case of disobedience of the requirements of a subpoena issued by the court.

(5) If any person, agency or facility fails to comply with an order of the board issued pursuant to subsection (2) of this section, the judge of a circuit court of any county, on application of the board or its designated representative, shall compel obedience by

proceedings for contempt as in the case of disobedience of the requirements of an order issued by the court. Contempt for disobedience of an order of the board shall be punishable by a fine of $100. [1977 c.380 §9; 1989 c.980 §8]

Note: 161.395 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.397 Psychiatric Security Review Board Account. The Psychiatric Security Review Board Account is established separate and distinct from the General Fund. All moneys received by the Psychiatric Security Review Board, other than appropriations from the General Fund, shall be deposited into the account and are continuously appropriated to the board to carry out the duties, functions and powers of the board. [2001 c.716 §3]

Note: 161.397 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.400 Leave of absence; notice to board. If, at any time after the commitment of a person to a state hospital under ORS 161.341 (1), the superintendent of the hospital is of the opinion that a leave of absence from the hospital would be therapeutic for the person and that such leave would pose no substantial danger to others, the superintendent may authorize such leave for up to 48 hours in accordance with rules adopted by the Psychiatric Security Review Board. However, the superintendent, before authorizing the leave of absence, shall first notify the board for the purposes of ORS 161.326 (2). [1981 c.711 §12]

161.403 [1983 c.800 §14; repealed by 1993 c.77 §1]

INCHOATE CRIMES

161.405 "Attempt" described. (1) A person is guilty of an attempt to commit a crime when the person intentionally engages in conduct which constitutes a substantial step toward commission of the crime.

(2) An attempt is a:

(a) Class A felony if the offense attempted is murder or treason.

(b) Class B felony if the offense attempted is a Class A felony.

(c) Class C felony if the offense attempted is a Class B felony.

(d) Class A misdemeanor if the offense attempted is a Class C felony or an unclassified felony.

(e) Class B misdemeanor if the offense attempted is a Class A misdemeanor.

(f) Class C misdemeanor if the offense attempted is a Class B misdemeanor.

(g) Violation if the offense attempted is a Class C misdemeanor or an unclassified misdemeanor. [1971 c.743 §54]

161.425 Impossibility not a defense. In a prosecution for an attempt, it is no defense that it was impossible to commit the crime which was the object of the attempt where the conduct engaged in by the actor would be a crime if the circumstances were as the actor believed them to be. [1971 c.743 §55]

161.430 Renunciation as a defense to attempt. (1) A person is not liable under ORS 161.405 if, under circumstances manifesting a voluntary and complete renunciation of the criminal intent of the person, the person avoids the commission of the crime attempted by abandoning the criminal effort and, if mere abandonment is insufficient to accomplish this avoidance, doing everything necessary to prevent the commission of the attempted crime.

(2) The defense of renunciation is an affirmative defense. [1971 c.743 §56]

161.435 "Solicitation" described. (1) A person commits the crime of solicitation if with the intent of causing another to engage in specific conduct constituting a crime punishable as a felony or as a Class A misdemeanor or an attempt to commit such felony or Class A misdemeanor the person commands or solicits such other person to engage in that conduct.

(2) Solicitation is a:

(a) Class A felony if the offense solicited is murder or treason.

(b) Class B felony if the offense solicited is a Class A felony.

(c) Class C felony if the offense solicited is a Class B felony.

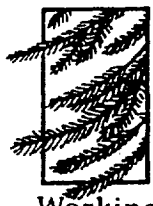
(d) Class A misdemeanor if the offense solicited is a Class C felony.

(e) Class B misdemeanor if the offense solicited is a Class A misdemeanor. [1971 c.743 §57]

161.440 Renunciation as defense to solicitation. (1) It is a defense to the crime of solicitation that the person soliciting the crime, after soliciting another person to commit a crime, persuaded the person solicited not to commit the crime or otherwise prevented the commission of the crime, under circumstances manifesting a complete and voluntary renunciation of the criminal intent.

(2) The defense of renunciation is an affirmative defense. [1971 c.743 §58]

RIGHTS OF THE MENTALLY ILL



OREGON ADVOCACY CENTER

Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

Voice: 503-243-2081 • 1-800-452-1694 • TTY: 1-800-556-5351 • Fax: 503-243-1738
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WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

. . . . .

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders.**

. . . . .

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

. . . . .

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

. . . . .

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

> Has a mental disorder and, because of that mental disorder, is:
>
> Dangerous to self or others, or
>
> Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

> Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING

A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT

In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

Section 3 - RESOURCES

- Family and Consumer
- Community Resources
- Medications

FAMILY AND CONSUMER

PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone wants to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes them uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending tiredness that ultimately gets you. You kill yourself because you have to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You <u>have</u> no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
(503)238-0769 • FAX(503)233-2801

January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domaciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

http://www.psych.org/public-infor/MEDS~1.HTM 7-15-99

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting, sweating, delayed orgasm

http:noah.cuny.edu/illness/mentalhealth/cornell/medications/antidepsideff.html 7-15-99

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly **rapid tolerance** and are extremely **difficult to withdraw** from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do **not produce tolerance**. The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics
Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The second generation or "atypical" compounds
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The SSRI's (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The MAOs (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The **ANTI-MANICS (also referred to as mood stabilizers)** are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. **Non-addictive** and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The "new generation" anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. These **medications can produce dependence and tolerance.** They are less often prescribed now as many of the **SSRI anti-depressants** and a

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL) MESORIDAZINE (SERENTIL) TRIFLUOPERAZINE (STELAZINE) THIOTHIXENE (NAVANE) RESPERIDONE (RISPERDAL) LOXATANE (LOXAPINE) CHLORPROMAZINE (THORAZINE) HALOPERIDOL (HALDOL) THIORAZINE (MELLARIL) PIMOZIDE (ORAP) MOLIDONE (MOBAN) CHLORPROTHIXENE (TARACTAN) FLUPHENAZINE (PROLIXIN) TRIFLUOPERAZINE (STELAZINE) PERPHENAZINE (TRILAFON) CLOZAPINE (CLOZARIL)	Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention. Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia. Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulusant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE= meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Floricet	NAR	butalbital with aspirin
Florinal	NAR	butalbital with tylenol
Flexoril	MR	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AA	propranolol
Isoptin	AA/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AA	clonazepam
Librium	AA	chlordiazepoxide
Lioresal	MR	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAR	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thiorazine
Miltown	AA	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine
Percocet	NAR	oxycodone with tylenol
Percodan	NAR	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAR	acetominophen with codeine
Tylox	NAR	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Xanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MR
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations,

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

Compiled by Project Respond for the Portland Police Department.